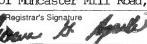
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Claudia Marie Colleli March 22, p 2005 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Montgomery Hospice- Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🕮 F 579-40-1042 73 Yrs. Director 1932 Feb. 6, Washington, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
snt: If item 27 is marked other than "natural, or items 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4016 Havard Street 20906 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 Specify: White 1 ☐ Yes 21 No Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government Human Resources Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be nt of Health and Menta :: If item 27 is markad gr other treumetic Walter Edward Thompson Catherine Aghetta Doherty ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4016 Havard Street, Silver Spring, MD 20906 Francis E. Colleli/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 28, 1

Burial 2 □ Cremation 3 □ Removal from State injury of permit. Page Department of Importent: If any injury or once. Gate of Heaven Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 23a. Part1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypercalcenia /Medical Due to (or as a consequence of): **Examiner** Metastatic Bladder Cancer Sequentially list conditions, if any, leading to immediate the first linearing Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requiras that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 X No Month Dav Year 5 Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 s autopsy performed? 1 ☐ Yes 2E No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Stother (Specify) Hospice funeral din 1 Yes 2 X No Certification: To 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Facility After 1 ANatural Injury s after dec. rel Diractor; After 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison, M.D. 6001 Muncaster Mill Road, Rockville, MD 20855

State Registrar 31. Date filed (Month, Day, Year)
MAR 2 4 2005



JAMES L.CHEW 05-02012 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Year Month Chew **Physician** James L. MARCH 2005 2:40A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK CALVERT 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Y. Nov. 10, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Days Months Min. Hours 1 □ XM 2 □ F 1954 212-66-4333 50 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County , or Itams 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Prince Frederick Director Maryland Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20678 2075 Mackall Road USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify: Specify: Black If Yes, Give δ 3 ☐ Widowed 4 X Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any injury or other traumatic event, Item May injury or other traumatic event, Item May College (1-4or 5+) Elementary/Secondary (0-12) 1 2 Custodian Maintenance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Chew, Jr. Louis Hampton Wallace Bertina 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Leonard Chew/Brother 902 E Royal Street Annapolis, MD 21401 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition ErnestineJonesCem. 3/24/05 1 Durial 2 Cremation 3 Removal from State Chesapeake Bch., MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Fred., MD20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardioverseu Physician Atheroschrohe /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Cher (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No 24a. Was an certificate has autopsy performed? 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1X Yes 2 □ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 24 hours a Funerel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME 5 HHWall, MIS MARCH 20,2005 30. Name and ad sof person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 tamela E. Southall, MD 31. Date filed (Month, Day, Year) 32. Registra Signature State MAR 2 3 2005 Registrar

_			1 - For State Registrer	State of Man	/land / Dep		t of H	ealth a		-		005	12003
	Physic	an	Decedent's Name (First, Middle, La.							2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi		Anita Louise C							March_	22,	2005	8:26 ^{am}
	Examir	ner	4a. Fecility Name (If not institution, give					Location o				ounty of Death	
			Calvert Memoria: 5. Social Security Number 6. S		a um la at histoslav			Frede				alvert	
-01	Funeral Director		-	ox 7. Age (# □M 2020 F	n yrs. last birthday, 71 Yrs.	Months	Days	Hours		8. Date of Bird (Month, Da	th y, Year)	Coul	place (State or Foreign ntry)
Н			Usual Residence of Decedent							Apr. 1	5, 19:	33	
	how how		10a. State 10b. County	10	c. City, Town or L	ocation						1	Od. Inside City Limits
	e Ma	cto	WA Pacific	2	Ocean P	ark							1 □ Yes 2x No
	or 28	Dire	10e. Street and Number			10f. Zip	Code				10g. Citíze	n of What Cou	ntry?
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	and and n 27		Harding G. Carls	on_(Husband) P.O	. Box	159	7 Oce	an Pa	ark, Wa	ashing	gton 986	640
ore	of H		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐	!	20b. Place of Dispo cemetery, cre			e)	Da	ate	20c. Loca	tion - City or To	own, State
Ë	ment tent: jury		`4 □ Donation 5 □ Other (Specification))	Lee Crem					-2005	Cli	nton, l	<u>/</u> D
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show emportent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show emportent: If item Medical Examinar must be putified at once.		21. Signature of Funeral Service Licer	11/2	8	2. Name and 125 Sc	d Addres	s of Facility	y Lee aryla	Funera and Blv	d., C	e Calve wings,	ert P.A. MD 20736
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ğ	w require been sign should b											1 🗆 Y	es 2	□No 3□Pr	obably 4 Unknown
Records,	e law r has be je 2 sh	Completed										24a. Was autop	sy	prior to	topsy findings available completion of cause of
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	o the	Mec	29b. Signature and titl	le of certifier	and mani	or stated.		29c	. License	number			29d. Da	te signed (Mont	h, Day, Year)
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•	(2/1)		30. Name and addres	s of person w	ho completed caus	e of death (Iter	n 23a) (Type,	Print)	1.6	V-			J/	- 6	
	790		Richard J	. Feldr	nan, M.D.	9500	Annapo		d	#A-4	Laı	nham, M	D. 2	0706	
	Sta		MAR 2 4	2005 ^{Year)}	32. R	egistrar's Sign	ature								
	Regist	rar			1	7									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2005 Year March 16, Physician 4:15 p M Lucie C. Chapmon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Wheaton Randolph Hills Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 🚜 🔀 F Aug. 17, 1917 Richmond, VA Director 577 50 7811 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County , or Items 23s or 28s-f show other treumatic event, the Medical Examiner must be notified at XX Yes 2 No tō Washington DC Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20018 1304 W Street, Northeast death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes �� No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 🛠 🔀 No Specify: Specify: Black þ 3 Widowed 4XX Divorced "netural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other treumstic event, ITE Me. College (1-4or 5+) Elementary/Secondary (0-12) Private 1 Yr. Cosmotologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anise Hill Peter Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Capitol Heights, MD 20743 <u> Annise Chapmon / Daughter</u> 10 Daimler Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 03/24/2005 Brentwood, MD 22. Name and Address of Facility Marshall's Funeral Home of MD 21. Signature of Funeral Service Licensee Suitland, MD 20746 4308 Suitland Rd. aus 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Failure To Thrive /Medical Due to (or as a consequence of Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Litter crucerlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1⊡Yes \$xt5xNo detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably XXUnknown Completed Dementia, Psychosis Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No certificate XX No 1 ☐ Yes or Attending Physician: 26. Place of Death Check onl one funeral director, 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XX No Certification: To 28a. Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury XXNatural 5 Pending after death.

Director: Aft of in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospitel o within 24 hours aff State

Anuradha Arun, M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAR 2 5 2005

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

un M

29d. Date signed (Month, Day, Year)

March 21, 2005

10301 Georgia Ave. Suite 209 Silver Spring, MD

			For State Registrar	State of	Maryland		artment of H tificate of L			F	Reg. No.	UHA	12006
			1. Decedent's Name (First, Midd	le, Last)			-			2. Date of Dea		Year	3. Time of Death
	Physici /Media		JOAN BERRY DUNI	LAY						03		2005 ^{ar}	
	Examir		4a. Facility Name (If not institution				4b. City, Town, or					County of Dea	
			CIVISTA ME				LA PLA					HARLE	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. I		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birt (Month, Day May 29	h / Year)	9. Bir	thplace (State or Foreign ountry)
	Director		046-14-7643	X.	84	Yrs.				May 29	1920) Co:	nnecticut
	pu *		Usual Residence of Decedent 10a. State 10b. County	v	10c. City	, Town or Lo	cation						10d. Inside City Limits
	ith the Marylar or 28a-f show	ō	Maryland Charl	Les	Wald	orf							1 □XYes 2 □ No
	the N	ect	10e. Street and Number				10f. Zip Code				10a. Citi	zen of What C	ountry?
	with	급	2309 Valery Cou	ırt				602				US	·
	death with the Maryland ms 23a or 28a-f show rmast be notified at	eral	11. Marital Status	12. Was Deced	ent Ever in U.	S. 13. 1	Was Decedent of H If Yes, specify Cuba		rigin? (Spe	ecify Yes or No-	.	14. Race - Am	erican Indian,
-	ter d	Ë	1 ☐ Never Married 2 ☐ Ma	Armed Force	es?					Rican, etc.)		Black, Whi	te, etc.
3	irs af	by	3√∑ Widowed 4 □ Divorce	If Vac Give	es:		1 ☐ Yes 2 ☐ No	Specify	:			Specify:	White
1411a	Z I Z I D-UUSO d within 72 hours after dea giene. ar than "natural", or Items the Modical Ere in or In	ted	15. Decede	nt's Education		16a. Dece	dent's Usual Occup	ation	at of worki		16b. Ki	nd of Business	/Industry
5	2	ple	(Specify only high	est grade completed) College (1-4	for 5+)		kind of work done of DO NOT use retired	d)	St Of WORK	,,,g	_		
2	d with	mo:	12			Ho	omemaker					m Home	
	othe vant	Be Completed by Funeral Director	17. Father's Name (First, Middle	, Last)						e (First, Middle,		Sumame)	
•	Maryiand Z 1 Z 1: Id 2 should be filed within in and Mental Hygiene. 27 is marked other than "traumatic event, the Mary	2	Edwin F. Berry										
	ary and I	1	19a. Informant's Name/Relation	. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or									
	6 4 2 7		Rosheen McGowar	sheen McGowan (Daughter) 1205 Jefferson Lane Waldorf, MD 2									
8	of He		20a. Method in Disposition 1 Darial 2 TyCremation	3 □Removal from Si	20b. P	lace of Dispo emetery, crei	osition (Name of matory or other place	ce)	C	Date	20c. Lo	ocation - City o	r Town, State
0 :	altimore, mit. Pages 1 a partment of Hee portant: If itam y injury or otha		4 □ ponation 5 □ Other (Specify)	Met	ropol:	itan Crem	atory	7 3-	23–05	A1	.exandr	ia, VA
7	Baltimore permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of meral Service	e Licensee MOO	173		2. Name and Addres		Eb	erwein White			
	Physician		23a art1. Enter the disease, of shock, or heart lailure. Listing articles are shocked as a shock of the shock	st only one cause on ea	ch line.					or respiratory ar	rest,		Approximate Interval Between Onset and Death OLOUS
	/Medical		disease or condition resulting in death)	aDue to (o	r as a conseq	uence of):	mboli Ynrom!		^				
	Examiner			dee	PVLY	10w	throm!	bosco	3				weeks
	HEWSO.	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequ	uence of):							
	760, te be executed ysician and e burial-transit	Examiner	that initiated events	C									
	C, e exe an ar urial-t	EX	resulting in death) Last	Due to (o	r as a conseq	uence ol):							
j	876 cate be chysici the bu	icai		d									
	rtifica		IF FEMALE:	1									
	Division of Vital Records, P.O. Box 6876U, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	PFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta nt at time of d	I death 3	□Ectopic pregnancy □ Other <i>(specify)</i>	<i>y</i>				23d. Date of de Month	elivery Day Year
	IS, P.		Part II. Other significant condi	tions contributing to dea	ath but not res	ulting in the u	inderlying cause giv	en in Part	ł.	23e. Did t	obacco ı	use contribute	to the cause of death?
	d be	d by	Colon ca	ncer.						10	Yes 2	□No 3□F	robably 4 Unknown
	Division of Vital Records, to Attanding Physician: The law requires to after death. Director: After this certificate has been signed in by the funeral director, page 2 should be on the property.	Completed	Colon Ca emphy se	ma.						24a. Was	an	24b. Were a	autopsy findings available completion of cause of
1	Recarded the same of the same	mp	C/143104 SC	777							osy rmed?	death?	
	of Vital Rec nysician: The law nis certificate has I I director, page 2 s							00 DI-	4 D4	1 Yes	2 No	1 L Ye	s 2 No
	Vit sicial certil recto	Be	25. Was case referred to medic examiner?	Hospital:		FB/Out-ati-	nt 3 DOA Oth	200		h <i>(Check only c</i> ome 5 ☐ Resi		6 Other /Sa	aciful
,	Of Phys	. To	1 Yes 2 No		patient 2 Injury	28b. Time of				28d. Describe			outy)
	on of ding Ph After thi funeral	tion	1 Natural 5 ☐ Pend	28a. Date of (Month stigation)	, Day Year)	Injury		rk? ∣Yes 2[No				
	Visic r Attend er death rector: by the	Certification;	3 ☐ Suicide 6 ☐ Coul	d not be 28e. Place	of Injury - At he	ome, farm, st	reet, lactory, office			28f. Location (Street an	nd Number or F	Rural Route Number,
	Div lor A after Dire	erti	4 Homicide	buildin	g, etc. (Specif	y)				City or To	wn, State	9)	
	To tha Hospital within 24 hours a To the Funaral I completely filled	edical C	29a. Certifier 1 Certify (Check only 2 Medic	ying Physicien: To the al Exeminer: On the ba and mann	sis of examina	wledge, dea tion and/or in	th occurred at the timestigation, in my o	me, date a opinion, de	and place, eath occurr	and due to the red at the time,	cause(s)) and manner a d place, and du	as stated. ue to the cause(s)
	o the o the	Me	29b. Signature and little of certif	1.1/1/10			29c. Licens						nth, Day, Year)
	F S F O		> / //////////////////////////////////	M//////	,		D-464	419				3/22/0	5
			30. Name and address of person	or who completed cause	ol death (Iten	n 23a) (Tvpa	, Print)						
	NB		TETCHEODD	CHARIENE	A M	D 404	CHARLE	S SI	REE	r la p	LAT	A MD 2	20264
	SI	ate	31. Date liled (Month, Day, Yea		strar's Signa	ature	boardes						
	Regis		MAR	2 4 2000		1							

			1 - For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artmen <i>rtificat</i>	t of He <i>e of D</i>	eaith and eath	Mentai Hy	/giene Reg. No		12008
	Physic /Medi		1. Decedent's Name (First, Middle, Las. Tamza Du	nn Ellio	tt			_	2. Date of Do Month	Da	y Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give			4b. City,		ocation of Deal	th	40	County of Death	1 ,
	Funeral Director		5. Social Security Number 6. Se 117-44-1927	x 7. Age (In yrs	s. <i>last birthday)</i> Yrs.	If Under Months	1 Year	If Under 24 Hrs Hours Min		rth ay, Year)	9. Birth	nplace (State or Foreign untry) Cyland
	yland Iow		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation						10d. Inside City Limits
	Ba-fsh	Director	Maryland Somerset	. P.	rincess	Anne	•					1 XYes 2 No
	with th		10e. Street and Number			10f. Zip	Code			10g. Ci	tizen of What Cou	intry?
	ns 23	Funeral	11974 Edgehill Te	Prace 12. Was Decedent Ever in	U.S. 13. V		1853	anic Origin? (S	Specify Ves or N	US	A 14. Race - Amer	ican Indian
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the multibol at ODGe.	by Fun	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:	1	f Yes, spec 1 ☐ Yes		Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Black, White	
21215-0036	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	dent's Usua	al Occupation	on ring most of wo	dring	16b. K	ind of Business/li	
121	within ane. than *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT us	se retired)		ikiig			
<u>б</u>	filed Hygie other ent, II	Be Co	12 17. Father's Name (First, Middle, Last)	2	FLOII	C ENG	Mana		me (First, Middle		ocery St	ore
Maryland	uld be Vental rrked tric ev	To B	Dawson Warner Dunn					anda Pr			,	
lar)	2 sho and h is ma	·	19a. Informant's Name/Relationship (7)		19b. Mailin	g Address	(Street and	d Number or Ri	ural Route Numb	er, City	or Town, State, Zi	p Code)
	1 and Health em 27 ther tu		William David Mer 20a. Method of Disposition		1185 Place of Dispos	50 Ed	gehil	l Terra	ce, Pri			MD 21853
μOπ	ages ant of I it: if it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	cemetery, cren	natory or o	ther place)	1 2 /2			ocation - City or T	
Baltimore,	mit. F partme sortan r injur		21 Si nature of Funeral Service Licens		ttsvil]				6/05	Pit	tsville,	MD
<u>~</u>	permi Depar Impor any ir	1.5	David H. Dom	DONC CESP	<u> </u>	101101 501 Si	way fi now Hi	uneral ill Rd.	Home Pro . Salish	ofes:	sional A , MD 218	ssociation
U			23a. Part1. Enter the disease, or comp shock, or heart failure. List only or	ications that caused the dea	ath. Do not ente	er the mode	e of dying,	such as cardia	or respiratory a	rrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	1	evi)							Onset and Death
ľ	Examiner			Due to (or as a conse	quence of):	1, we						
	B #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse		100						
	ecutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	»								
60,	icate be executed physician and s the burial-transit	al E	, see	Due to (or as a conse	quence of):							
68760	tificate ig phys	edicai										
Box	eath certifications attending properties as	an/M	zoo. Has decedent pregnant	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet		Ectopic pre	anancy				23d. Date ol deliv	ery
0.	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown		Other (spe					Month	Day Year
S, J	es that gned t	by P	Part II. Other significant conditions cor	tributing to death but not re-	sulting in the un	derlying ca	iuse given i	n Part I.	23e. Did to	obacco u	se contribute to t	he cause of death?
Hecords,	w requir been si should								1 🗆 ነ	Yes 2[□No 3□Prot	pably 4 dunknown
Zec Zec	The law rate has b page 2 s	Completed							24a. Was autop	osy	24b. Were auto	psy findings available mpletion of cause of
		e C0	25. Was case referred to medical						1 Tes	2 No	1 Yes	2□ No
<u> </u>	Physician: r this certific ral director.	To B	examiner?	ospital: 1 Inpatient 2	ER/Outpatient	3□ DO/	04		th (Check only o		5 □Other (Specif	14)
n ot	ding Ph th. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		3c. Injury at Work?		28d. Describe h			<i>y</i> /
DIVISION	ttendi death. :tor: A :the fu	catl	2 Accident investigation 3 Suicide 6 Could not be			M	1 🗌 Yes	2 □ No				
2	tal or Attending F s after death. al Director: After ed in by the funer	Certification	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, larm, stre	et, lactory,	office		281. Location (S City or Tou		d Number or Rura)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	ician: To the best of my knower: On the basis of examination and manner stated.	owledge, death ation and/or inve	occurred a estigation,	t the time, in my opini	date and place on, death occu	, and due to the or rred at the time, or	cause(s) date and	and manner as s place, and due to	tated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c.	License nu	ımber		29d. Date	e signed (Month.	Day, Year)
	0		Nalev				8 4	7094			3/25705	
	3			+TE3AN	m 23a) (Type, P	Print) GUUT	0	V. 510N	sheet	5	4C15BVP	4 MD 21804
	Star Registra		31. Date liled (Month, Day, Year) MAR 2 8 20	32. Polistrar's Signa	ature A	mark .	,					

State of Maryland / Department of Health and Mental Hygiere State Registrar AMEND ITEM #8 PER FH C845 7 Portificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EBY 200S /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death HOW CRUSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1942 9. Birthplace (State or Foreign Country) Days Hours 11☑M 2□F 552-56-2457 62 Yrs. Director California November 17,2005 Usual Residence of Decedent with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinating the notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1X Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8600 16th Street 20910 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Heatth and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, the DDCS Economist Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eldan Eby Unknown Koser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth S. Eby/ Wife 328 11th Street S.E. Washington, D.C. 20003 20b. Place of Disposition (Name of cemetery, crematory or other place).

Georgetown University 20a. Method of Disposition March 2005 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 Donation 5 ☐ Other (Specify) Washington, D.C. Medical Center Signature of uneral Service Licencee 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE Physician disease or condition resulting in death) 2 WKS /Medical Examiner RECURRENT PNEUMONI AS 2 MON7(# fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed burial-transit and resulting in death) Last Division of Vital Records, P.O. Box 68760 the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MONOCLONAL GAMMOPATHY, PANCY TO PEN (A. 1931 DURA) 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 1BSCESS, METHACILLIA SONSITIVE STAPHYLOCOCCUS AURBA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy SERS ARIAC PRILATION

25. Was case of fer ed to medical examiner? ormed? 2 No 1 Yes To the Hospital or Attending Physician: Be 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 3 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 28d. Describe how injury occurred 5 Pending death. Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗋 Suicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P36252 2 30. Name and address of person who p impleted cause of death (Item 23a) (Type, Print), STEVEN 7, KARIYA, MD, 11501 GEORGIA-AYE #575, WHOTON MD 20902 State Registrar

			1 - For State Registrar	State of M	Maryland / De	epartmei Certifica					ene g. No.	05	120	10
	Physici		Decedent's Name (First, Middle, L. Jean Fackto	,					N 1	ate of Death Month rch	Day 29	Year 2005	3. Time o	of Death A M
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number	r)	4b. City	, Town, or	Location of	of Death			ty of Death		
			Harford Memoria	l Hospita	1	F	lavre	de G	Frace		Har	ford		
	Funeral Director		344-09-0131	Sex 7. A 1 ☐ M 25CX F	nge (In yrs. last birtho 93 Yr	Months	Days	If Under Hours	24 Hrs. 8. D Min. Ap	Pate of Birth Month, Day, CIL 4,	^Y •4 ⁷⁾ 1911	9. Birthp	place (State ptry) LNOIS	or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location						1	10d. Inside C	City Limits
	Maryl f sho	ļō	MD Harfo	rd	Havre	de Gr	ace							s 2 X No
	r 28e	Director	10e. Street and Number		1100720		p Code			10	g. Citizen of	f What Cour	ntry?	
	th with		3948 Loch Leven	Drive		2	1078				U.S.	.A.		
	ems	Funeral	11. Marital Status	12. Was Deceder		13. Was Dece	dent of Hi	ispanic Ori	igin? (Specify '	Yes or No-	14. Ra	ace - Americ ack, White,		
36	or It	by Fu	1 □ Never Married 2 □ Married	1 ☐ Yes 2 ☑ If Yes, Give	₹ No	1 🗆 Yes		Specify:		,,		ify: Whit		
00	hour turel		3 Widowed 4 □ Divorced 15. Decedent's E	Year or Dates		ecedent's Us	ial Occupa	ation		1	6b. Kind of			
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. do other than "naturel", or Items 23a or 28e-f show event, I're Medical Examinat retails to notified at	Completed	(Specify only highest gi	ade completed)		ive kind of w fe. DO NOT	ork done a	durina mos	t of working	'	ob. Kind or	Dusiness/in	dustry	
212	e filed within al Hygiene. cother than "	mo	Elementary/Secondary (0-12)	College (1-4o		memake	er				In ho	emc		
pu	be filed tal Hygid d other	Bec	17. Father's Name (First, Middle, Las	t)					er's Name (Firs	st, Middle, M	aiden Suma	ime)		
yla	2 should be and Mental Is marked eumetic ev	2	Simon Crasko						.sha					
Maryland	ges 1 and 2 should it of Health and Mer if item 27 is marke or other treumetic		19a. Informant's Name/Relationship Marsha I. Lauck						er or Rural Rou ., Havi					,
	1 and 1 Health Iem 27 other tr		20a. Method of Disposition	Daugiicei	20b. Place of D	- Introduction		en Dr	Date	-	Oc. Location		21078	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 [e cemetery,	crematory or	other place					•		
華	nit. Partme ortan injur		 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice 		R. A. F	22 Name a	nd Addres	s of Facilit	3/30/05		est Ch		:, PA	
B	permi Depa Impo eny is		*Kusten A.	(neles	bei	Tarri	ng-Ca	Mary	Funeral land	L Home	, P.A.	•		
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications hat cause	ed the death. Do not								Approxima Interval Be	ite
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. XS I	pratio s a consequence of)	~	$\overline{}$		DNIA			[€	Onset and	peath On
		ıer	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence of)									
	icate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.										
Ö,	e exerian ar urial-t		resulting in death) Last	Due to (or a	s a consequence of)		_							
8760,	cate be ex physician the buria	dical		d										
9	n certific anding p use as	/Med	IF FEMALE:	23c. If yes, outcom	e of programmy	-					1			
Вох	atte for	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 ☐ Fetal death at time of death	3 □Ectopic p 5 □ Other (s						ate of delive lonth		Year
o.	that the de ed by the detached	Jyst	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		0 0 0 0 10 10								
٣.	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions	contributing to death	but not resulting in th	e underlying	cause give	n in Part I.	. 2	23e. Did toba	acco use cor	ntribute to th	ne cause of	death?
rď	v require been sig should b		Advanced	Alzh	eimers	\mathcal{D}_{t}	me	ntia	<u> </u>	1 🗆 Yes	2 No	3 ☐ Prob	ably 4 🗌	Unknown
ecc	has be	plet	talure	4,4	h VIVE				2	24a. Was an autopsy	24b.	. Were autop	psy findings	available
E .	Th ate pag	Completed	10011000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					1	perform	ed? No	death?	2 No	
Vital Records,	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			0# -		of Death (Che	eck only one)			
of	Phys this al dii	. To	1 Yes 2 No	Hospital: 1 Inpat			OA Othe 28c. Injury	4 🗆 140	rsing Home	5 🗌 Residen Describe how			1)	
on	ding h. After fune	tlon	16 Natural 5 ☐ Pending	28a. Date of In (Month, D	ay Year) Inju	ry M	Work	ai ? /es 2 □!		Describe NOW	v injury occu	iiiea		
Division	Attending r death. sctor: After by the fune.	flca	3 Suicide 6 Could not I	28e. Place of Ir	njury - At home, farm				28f. L	ocation (Stre	et and Num	ber or Rura	I Route Nun	nber,
á	al or safter	Certification:	4 Homicide	building, e	etc. (Specify)					City or Town,	State)			
B	To the Hospital or Attending lwithin 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical (29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the bes miner: On the basis and manners	it of my knowledge, d of examination and/o stated.	eath occurred r investigation	at the tim	e, date an	d place, and d th occurred at	ue to the cau the time, dat	use(s) and m e and place	nanner as st , and due to	ated. the cause(s)
	To the Within To the comple	Me	29b. Signature and title of certifier	_		29	c. License	number		290	d. Date signe	ed (Month, I	Day, Year)	
2	-) (YX	-nf)		DIO	158	3	1	larc	h 2	9,2	205
5			30. Name and address of person who	completed cause of	death (Item 23a) (Ty	pe, Print)	A	, ct	-A	Xb.	endo	0 - 1	100	100
			31. Date filed (Month, Day, Year)	Kzatn	trar's Signature	41	w	211	eer,	/ 1-		210	2017	ioma
* .	Sta Registr			2005	use It	Sports	,					•		
	•		8 4 6 4 7 7	1000	10									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 9.15AM G. FORD DONALD 05 26 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MD COASTAL HOSPICE SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 ☐ F 214-34-8311 Director 66 Maryland Usual Residence of Deceden the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show itam 27 is markad othar than "natural", or itams 23a or 28a-f shov othar traumatic evant, the Medical Examinar must be notified #1 1 ▼Yes 2 No Director Maryland Somerset Crisfield 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 73 Richardson Ave. 21817 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. sm 27 is marked other then "netural", or Itel 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: white Specify: If Yes, Give Year or Dates: Army þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security 8 Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emory H. Ford Sr. Sarah Mae Tyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any Injury or othar tra Dianna Ford/wife 73 Richardson AVe., Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State ' 4 □Donation 5 □ Other (Specify) Salisbury Crematory 3/28/05 Salisbury, MD 21. Sign three of Funeral Service Livensee 22. Name and Address of Facility Holloway Funeral Home Professional Association ax1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final sease or condition resulting in death) NEOLADNIA Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisace or injuly) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No 3 Probably 4 Unknown FALLURA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2√2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death al or Attending P s after death I Director: After Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier T714256. Sacaca 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COASTRC HOSTICE 100 SAACS GALIGRORY 31. Date filed (Month, Day, Year) MAR 2 8 2005 distrar's Signature State Registrar

		For State Registrar	State of Ma	-	•	nt of Health ai te of Death	nd Mental Hy	giene	2005	100) [(
Physicia		1. Decedent's Name (First, Middle, Las George F. Fitzroy					2. Date of De Month March	eath Day	Year 2005	3. Time of 8:44	Death C.
/Medic Examin		4a. Facility Name (If not institution, give	street and number)	ınty	E1kt			Ce	County of Death		
Funeral Director		5. Social Security Number 6. Security Number 1 041 22 8870 Usual Residence of Decedent	9x 7. Ag X M 2 ☐ F	e (In yrs. last birthe 70	Months	or 1 Year If Under 2 Days Hours	4 Hrs. 8. Date of Bi Min. (Month, D July 22	ay, Year)	Cou	place (State o. Intry) e Islan	
Maryland f show	tor	10a. State 10b. County		North Ea						10d. Inside Cit 1X Yes	•
with the Se or 28a- 1 be rotif	Director	Maryland Cecil 10e. Street and Number		NOT CH Ea		ip Code		•	zen of What Cou	1	
s 1 and 2 should be filed within 72 hours after death with the Maryland Ffeath and Mental Hygiene. If the this are a second to the theorem of the marked other then "naturel", or Items 23e or 28e-f show other traumatic event. It is Wedfall Evaluation must be rediffed at	by Funeral	201 Howard Street 11. Marital Status 1 □ Never Married ② Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1XYes 2 1 If Yes, Give Year or Dates:		13. Was Dec	edent of Hispanic Origi ecify Cuban, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)		14. Race - Amer Black, White	ican Indian, , etc.	
thin 72 hour e. en "naturel Medicul Er	Completed b	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation		ecedent's Us Give kind of w ife. DO NOT	ual Occupation ork done during most use retired)	of working		nd of Business/li	ndustry	
ould be filed with Mental Hygiene arked other the atic event, The	Be	12 17. Father's Name (First, Middle, Last)	2	Wel	der		s Name (First, Middle		ding Sumame)		
2 should be and Mental is marked c	T ₀	George F. Fitzroy 19a. Informant's Name/Relationship (7)				ss (Street and Number		2010			
Pages 1 and nent of Health int: If item 27 iry or other tr		Rosalee Fitzroy/W 20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of D	Disposition (Nation of Crematory of		Date	20c. Lo	cation - City or T	own, State	
permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	8	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Superal Supe		Cemet	22. Name	thodist Ma and Address of Facility outh Main S	Crouch Fu	neral		•	
		23a. Part1. Enter the disease, or companies on the control of the	^		t enter the mo	ode of dying, such as c	ardiac or respiratory	arrest,	CTION	Approximate Interval Bety Onset and I	e ween
Physician /Medical Examiner		disease or condition resulting in death)	0 -	a consequence of	IFERIA HRTEA	_	ASE	1 7 1	21401		
outed nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· ATA		IBER:	LLLATTO!	V				
cate be executed physician and the burial-transit	dical Ex	resulting in death) Last		a consequence of		НУ					
The law requires that the death certificate ate has been signed by the attending physogge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 □Ectopic 5 □ Other (2	23d. Date of deli Month	•	Year
tw requires that to seem signed by schoold be detailed.	by	Part II. Dther significant conditions of	ontributing to death b	out not resulting in t	the underlying	cause given in Part I.		tobacco u	se contribute to	the cause of d	
	Completed						24a. Wa auto per 1 🗆 Yes	s an opsy formed? 2 No	death?	topsy findings ompletion of ca 2 No	
iing Phys n. After this funeral di	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Autural 5 Pending investigation	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	ury 28b. Tii		Other	of Death (Check only sing Home 5 - Res 28d. Describe	sidence (ify)	
To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined		jury - At home, farr tc. (Specify)			28f. Location	(Street an own, State	d Number or Ru)	ral Route Num	iber,
he Hospit n 24 hours he Funere	edical (29a. Certifier (Check only one)	ysician: To the best niner: On the basis o and manner st	of examination and	death occurre for investigation	od at the time, date and on, in my opinion, deat	place, and due to the h occurred at the time	, date and	place, and due	to the cause(s	;)
To the withir To the comp	M	29b. Signature and Hitle of certifier	Van	-,m)		9c. License number C10005235			e signed (Month)		
+ IVA		30. Name and address of person who	VARMA	, MD	ype, Print)	45					
Sta Regist	atė rar	31. Date filed (Month, Day, Year) MAR 2 4 2005	32. Regist	rar's Signature							

George Fit

CO	kp	- State Registrar		Ce	ertificate of	Death		Reg. No. 2	1201
Physici	an	Decedent's Name (First, Middle					2. Date of De Month	$_{\rm Da}$ 03/19 $_{\rm A}$	05 3. Time of Death
/Medic	cal	Eleanor Turner			1		August	81 -92 0	- 11:30 P
amin	ier	4a. Facility Name (If not institution)		r Location of Death	1	4c. County of De	
ral		Laurelwood Care 5. Social Security Number		ge (In yrs. last birthda	Elkton If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	Cecil	
		041-16-9981	1 □ M 2 🛣 F	84 Yrs.	Months Days	Hours Min.	(Month, Da	rth v 0,8 / 0,8 / 2 19,-2005	MA
		Usuel Residence of Decedent					Juocett 1	,, 2003	,,,,,
	_	10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limit
	Director	MD Cecil		Elkton					1 X Yes 2 □ N
	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	Funeral	100 Laurel Driv		Everin II C 10	21921	tii- O-i-i-2 /O-		USA	aciona Indian
	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was Decedent Armed Forces ad 1 \(\text{Yes} \) 2 \(\text{X} \)	?	. Was Decedent of H If Yes, specify Cub	an, Mexican, Puert	pecity Yes of No o Rican, etc.)	Black, Wh	nerican Indian, nite, etc.
	by F	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: (t)h	ite
	ted	15. Decedent		16a. Dec	edent's Usual Occur	pation		16b. Kind of Busines	
	Completed	(Specify only highes Elementary/Secondary (0-12)	grade completed) College (1-4or	(Giv	e kind of work done DO NOT use retire	during most of wor. d)	king		
	МО	12	00590 (1.10		memaker			Own Home	,
	Be (17. Father's Name (First, Middle, I				18. Mother's Nam	ne (First, Middle	, Maiden Surname)	
	Tof	Herbert A. Whee	lock			Hattie	E. Turn	ier	
		19a. Informant's Name/Relationsh	ip (Type, Print)		-			er, City or Town, State,	
	2	Brian Fairfield	/Grandson			nut Road		ı, MD 2192	
		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	3 □Removal from State	20b. Place of Disp cemetery, cr	oosition (Name of ematory or other pla	·	Date	20c. Location - City of	or Town, State
		*4 ☐ Donation 5 ☐ Other (Sp		Rosebank	Cemetery			Rising Su	
once.		21. Signature of Funeral Service	icensee	1:	22. Name and Addre	ss of Facility R. 7	r. Foara	d Funeral H Sun, MD 2	ome, P.A.
O		23a Part1. Phter the disease, or	complications that cause						Approximate Interval Between
ian cal neral-transit	dical Examiner	Immedial Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	s a consequence of): s a consequence of): s a consequence of):	Deme	5×71A			
	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnanc	y		23d. Date of d Month	elivery Day Year
	by	Part II. Other significant condition	ns contributing to death I	but not resulting in the	underlying cause gr	ren in Part I.		tobacco use contribute Yes 2 □ No 3 □ F	
	Completed						24a. Was auto pendo	psy prior to ormed? death?	autopsy findings available completion of cause of
	a ·	25. Was case referred to medical			-	26. Place of Dea			, <u>J</u>
	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpati	ient 2 ER/Outpati	ent 3 DOA Ott	ner: 4 Nursing H	ome 5 Resi	idence 6 Other (Sp	ecify)
		27. Manner of Death 1. Natural 5 ☐ Pending	a Date of Inj	ury 28b. Time	of 28c. Injui	y at	28d. Describe	how injury occurred	
	atle	2 Accident investig	ation			Yes 2 □No			
	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	nee 299. Place of in	jury · At home, farm, stc. (Specify)	treet, factory, office		28f. Location (. City or To	Street and Number or F wn, State)	Rural Route Number,
		29a. Certifier (Check only 2 Medice)	Phy Pien: To the best	t of my knowledge, dea	th occurred at the til	me, date and place	, and due to the	cause(s) and manner and di	as stated.
	Medical	one)	and manner s	tated.					
	2	29b. Signature and title of certiler			29c. Licens			29d. Date signed (Mor	
		1-17/ta	Win		154	0/3		21 Mar 0	> (
		30. Name and address of person	who completed cause of	death (Item 23a) (Type B () Cty- rar's Signature	o, Print) (Reckma	us c71	2 Ne	21 Marc	DE 1972
Sta egistr		31. Date filed (Month, Day, Year) MAR 2 2 20	32. Regist	rar's Signature	1.		,		

State of Maryland / Department of Health and Mental Hygiene 1 15

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			1 - For State Ragistrar		Ce	rtificate of		Work and Tri	Reg. No.	.000	12014
	Physic /Medi		Decedent's Name (First, Middle, La Homer Duke	•				2. Date of D Month Mar 29	Day	Year	3. Time of Death 7:00 A. M
	Exami		4a. Facility Name (If not institution, giv				or Location of Death)		County of Death	
			St. Mary's Nursi: 5. Social Security Number 6.5		e (In yrs. last birthday)	Leona If Under 1 Year	If Under 24 Hrs.	O Data of B		. Mary's	
	Funeral Director			X 2 F 7. Age	96 Yrs.	Months Days	Hours Min.	8. Date of B (Month, D	ay, Year)	Mary	
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary Fed	tor	Maryland St. Ma	rv's	Leonardtow	n					1 ☐ Yes 2 No
	or 28e	Director	10e. Street and Number	7	Deciliar acon	10f. Zip Code			10g. Citiz	en of What Cour	ntry?
	th wil		22680 Cedar Lane Cou	rt		20650			- 10	USA	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It if items 23s or 28e-f show or other than "natural", or Items 23s or 28e-f show or other traumatic event, the Medical Enamers must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	lo l	Was Decedent of Hif Yes, specify Cub 1 ☐ Yes 2 【 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)		4. Race - Americ Black, White, Specify: Whi	
<u>ب</u>	72 ho	ted	15. Decedent's E (Specify only highest gra		16a. Dece	dent's Usual Occup	pation	kina	16b. Kin	d of Business/Inc	dustry
21215-0036	d within 7 jiene. r than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retire	during most of world)	ung	Sta	te Govern	nent
	e filed al Hygir other vent,	Be C	17. Father's Name (First, Middle, Last,)	· · · · · · · · · · · · · · · · · · ·		18. Mother's Nam	e (First, Middle	e, Maiden S	Sumame)	
Maryland	2 should be n and Mental is markad raumatic ev	To	John Smyther Fore	ster			01ive	Ruth Duk	e		
lan	2 sho and is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, Zip	Code)
	and lealth m 27 her tr		Frank Goldbach/Gra	andson			Road, Lexi				
Ore	Pages 1 nent of H int: If ite iry or ott		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other pla	се)	Date	20c. Loc	cation - City or To	wn, State
Baltimore,	tmen tant:		' 4 □ Donation 5 □ Other (Specif		Charles Mer			1,2005	Leona	rdtown, Ma	ryland
Ba	permit. Pages 1 a Department of Hes Important: If item any injury or othe		21. Signature of Funeral Service Licer	Harlen	. Ma	Name and Address Attingley-Geonardtown,	ass of Facility Sardiner Fun MD 20650	eral Hom	e, P.A	., P. O. E	3ox 270,
	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter the cause Cause (Disease or injury)	b.	a consequence of a cons	ocade 1 Arte	al pr	farch	ion) / -	Interval Between Onset and Death
68760,	eath certificate be executed attending physician and for use as the burial-transit	al Examiner	that initiated events resulting in death) Last	Due to (or as a	a consequence of):						
687	ificate g phy as the	Medical		_ u.							
O. Box	The law requires that the death certie has been signed by the attendingage 2 should be detached for use	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	у		23	3d. Date of delive Month	Day Year
2	that ned by deta	y Ph	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to th	e cause of death?
SS	quires n sign							1 🗆	Yes 2	No 3 ☐ Prob	abiy 4 🗆 Unknown
Record	aw requir s bean si	Completed		Dement	10 =			24a. Was		24b. Were autor	psy findings available
æ	Tha lav	шо						auto perfe	ormed?	prior to cor death? 1 ☐ Yes	npletion of cause of
ta	ılcian; Th certificata rector, paç	0	25. Was case referred to medical				26. Place of Deat			1(1103	25140
>	Physician: r this certificate ral director, i	To B	examiner? 1 🗍 Yes 2 📆 No	Hospital: 1 Inpatie	nt 2 ER/Outpatien	t 3 DOA Oth	er: 4 Nursing Ho	ome 5 Res	idence 6	□Other (Specify)
Division of Vital	Attending PI or death. actor: After the		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time of Year) Injury	Wor	yat rk? Yes 2 □ No	28d. Describe	how injury	occurred	
Divis	al or Attending. after death. I Diractor: After d in by the funer	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inju- building, etc	ry - At home, farm, str. . (Specify)	eet, factory, office		28f. Location (City or To	Street and wn, State)	Number or Rura	l Route Number,
	To the Hospital or Attending Physician: Tha la within 24 hours after death. To the Funeral Diractor: After this certificata has completely filled in by the funeral director, page 2	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	iysician: To the best on niner: On the basis of and manner sta	of my knowledge, death examination and/or invited.	occurred at the tir	me, date and place, ppinion, death occur	and due to the red at the time,	cause(s) a date and p	and manner as sta place, and due to	ated. the cause(s)
	To the k within 2- To the k	Me	29b. Signature and title of certifier	1	1	29c. Licens	e number		29d. Date	signed (Month, L	Day, Year)
}			homa	H. land	MEM) D	0641	9	3-	-29-0	5
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)		1		V.1	
			Dr. J. Patrick Jar	boe, 24035 Ti	ree Notch Ro	ad, Hollywo	ood, Maryla	nd 20636			
	Sta	te	31. Date filed (Month, Day, Year)	V 32. Refistra	r's Signature						

DHMH 17 Rev 1/2001

State

Registrar

32. Redistrar's Signature

MAR 3 1 2005

		•	For State Registrar	State of Ma	aryland / [Departme <i>Certifica</i>			ınd M	ental Hy	rgiene Reg. No. 2 ()	0.5	12015
			1. Decedent's Name (First, Middle, Last)						2. Date of De		_Year	3. Time of Death
	Physici /Medic		Viola Eliz	zabeth	Frye					March	22, 2005		8:00 a M
	Examin		4a. Facility Name (If not institution, give			4b. C	•	r Location o			4c. County		
			Calvert County N					e Fre				lver	
	Funeral Director		214-16-8090	X 7. Age	e (In yrs. last bii 84	Yrs. Month	der 1 Year ns Days	If Under 2 Hours	Min.	8. Date of Bir (Month, De OCt.	1, 1920		place (State or Foreign ntry) yLand
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Location							10d. Inside City Limits
	within 72 hours atter death with the Maryland ene. than "naturel", or liems 23e or 28e-f show ta M. Jical Ex. uiher i nat be natified a	5			,	rince F	rođor	·i ak					1 ☐ Yes 2 🔀 No
	286-f	ecto	Maryland Calvert 10e. Street and Number		F.		Zip Code	ICK			10g. Citizen of V	Vhat Cou	ntry?
	with	늅				101.		678			U.S		,.
	eath	era	85 Hospital Road	12. Was Decedent I	Ever in U.S.	13. Was De			gin? (Spe	city Yes or No Rican, etc.)		e - Ame <i>r</i> i	can Indian,
40	ter d	표	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give					, Puerto I	Rican, etc.)		k, White,	
99	urs at	þ	3 X Widowed 4 □ Divorced	If Yes, Give 12 Year or Dates:		1 ☐ Yes	2 No	Specify:			Specify	wh	ite
21215-0036	2 ho	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad	cation	16a	Decedent's U			t of working	na	16b. Kind of Bu	siness/In	dustry
215	thin 7	old L	Efementary/Secondary (0-12)	Coffege (1-4or 5	+)	life. DO NO	T use retired	1)	or works	, g			
N	filed with Hygiene. other than	S	8			Wa	itres				resta		.t
pu	d oth	Be	17. Father's Name (First, Middle, Last)	~1 ·						-	, Maiden Sumam		
yla	should be fund Mental M	မ	William Edward	Chaney					ry	Irene			
Maryland	2 sho	il i	19a. Informant's Name/Relationship (T)			-	·				per, City or Town,		Code)
	and lealth m 27 her tu	1 1	Darlene F. Miller	, daughte		641 S. of Disposition (i		e St.		nrump,	NV 8904		Outro State
O.	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemete	ery, crematory	or other place					•	
Ē	tent:		`4 □ Donation 5 ☑ Other (Speqify,		nt So. I					8/2005	Dunkir	к, M	D
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or items 23e or 28e-1 show any nijury or other treumetic event, II a Maribal Examiner must be natified at once.		21. Signature of Funeral Service Licens	(octor	1			ss of Facility ICTAL		, P.A.	, Owings	, MD	20736
			23a. Part1. Ent. rt e disease, or comp shock, or hard failure. List only o	linations that caused	the death. Do	not enter the n	node of dyin	g, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final	E	Close					2		:	Onset and Death
1	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence		roni	C 4	ver	dis	euse_		nore than 141
н	Examiner			Cirrl	nosic	O.	Liver	+ Wi	tn	Ascil	100		
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of): O			11/	CIP ST			
	outed ansit	Ē	that initiated events	c. Chre	2 00	Hend	2417	5	C				
o,	an ar	icai Examinei	resulting in death) Last	Due to (or as	a consequence	of):							
8760,	certificate be executed ding physician and ise as the burial-transit	cal		d					_				1
9	ng pt as th		IF FEMALE:	NA.	CYTE		-						
Вох	es that the death certifics igned by the attending pt be detached for use as t	Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		h 3∐Ectopi	c pregnancy	,			23d. Dat	e of defiventh	ery Day Year
	requires that the death een signed by the atter nould be detached for u	sici	in the past 12 months? 1 Yes 2 No	4□ Pregnant at 9□ Unknown	time of death	5 🗌 Other	(specify)						
P.0	at the	Phy	9 Unknown			(_ <u> </u>		in Book I		22a Did	tobacca uso cont	ributa ta t	he cause of death?
	igned be d		Part II. Other significant conditions co	ntributing to death b	ut not resulting	in the underlyin	ig cause giv	en in Part I.	1		Yes 2 □ No	3 ☐ Prot	
brd	w requir been si should	ted	Hypertensive	HECO!	$rac{r}{c}$	rease	<u></u>			,,,			
ecc	- 0 70	Completed by								24a. Was	s an 24b. \	Vere auto	ppsy findings available impletion of cause of
E	The law cete has page 2 s	Ö								1 ☐ Yes	ormed? 2 ☑ No 1	Death? ☐ Yes	2 □ No
'ita	Physician: Th this certificete ral director, pag	Be (25. Was case referred to medical examiner?						of Death	(Check only	one)	-	
Ž	hysic his ca I dire	J.	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie			DOA Oth	4 La Nu			idence 6 Oth		fy)
u	ng P	on:	27. Mann Death 1 Patural 5 Pending	28a. Date of Inju (Month, Da	ry 28b. y Yea <i>r</i>)	Time of Injury	28c. Injur Wor			28d. Describe	how injury occurr	ed	
<u>S</u> i	Attending r death. ector: Atter	cati	2 Accident investigation			М		Yes 2 1					
Division of Vital Records,	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, fi c. <i>(Specify)</i>	arm, street, fac	tory, office		2	28f. Location (City or To	(Street and Numb wn, State)	er or Hur	ai Houte Number,
	ital c												
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exam	rsician: To the best iner: On the basis of	f examination ar	je, death occur nd/or investiga	red at the tir tion, in my o	ne, date an pinion, deat	d place, a th occurre	and due to the ed at the time	cause(s) and ma , date and place, a	nner as s and due t	stated. o the cause(s)
	the the mplet	Med	one) 29b. Signature and title of certifier	and manner sta	ated.		29c. Licens	e number			29d. Date signed	(Month,	Day, Year)
	To Too	1	250. Signature and the or certified	3 6/1	ana		D.		65	3	3.2		
7			1000	0 000	-		0				~		
	4	-	30. Name and address of person who c	ompleted cause of d	eath (Item 23a)	(Type, Print)	GYA	N -		SURX	ANA	75/	,
			5851 - Decele 31. Date filed (Month, Day, Year)	- Church	s Signature	KOUU	<u>^</u>	vea	C	m.2), 20	171	
	Sta Regist		MAR 2	2005 ► 2005	Engues.	K A	parte						

State of Maryland / Department of Health and Mental Hygiene 1 15

12016

	-				Cer	tificate of	Death	R	eg. No.	0 1	
	- :		1. Decedent's Name (First, Middle, Last)					2. Dete of Dea Month		Year 3	3. Time of Death
	Physicia /Medic		Bonnie Bahiyyah Le	e Faulk				March 1	7, Day 2005		*8:05pm
)	Examin		4a Fecility Neme (If not institution, give s					Location of Death	4c. County of	of Deeth	
			Larkin Chase Nursi				Bowie,		Prince		
Ì	Funeral Director		5. Social Security Number 248–40–7584 6. Sex Usuel Residence of Decedent		t birthday) Vrs.	If Under 1 Year Months Days	Hours Min		1917	9. Birthplace Country) SOUTH	(State or Foreign Carolina
	pue *		10a. Stete 10b. County	10c. City, T	own or Loc	cation				10d.	Inside City Limits
	Mary	ō	Maryland Prince Ge	eorge's Bowi	e						Yes 2□No
	1 the	Director	10e. Street and Number			10f. Zip Code	· · · · · · · · · · · · · · · · · · ·	1	0g. Citizen of W	hat Country?	,
	3a o		15107 Jennings Lane	9		2072	21		USA		
	death	Funeral		2. Was Decedent Ever in U.S. Armed Forces?	13. ¥	Vas Decedent of H Yes, specify Cubi	lispanic Origin? (S	Specify Yes or No-		- American I k, White, etc.	
Maryland 21215-0020	within 72 hours efter death with the Marylend ene. than "natural", or items 23s or 28s-f show he Medical Examiner must be nothed at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【X】Divorced	1 ☐ Yes 2℃ No If Yes, Give Yeer or Dates:		☐ Yes 2/CXNo	Specify:	to ritosii, etc.)			merican
5-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		(Give I	ent's Usual Occup	during most of wo	rking	16b. Kind of Bus	siness/Indust	iry .
21	ig e	현	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	1)		T. 3		
2	filed withii Hygiene. other then	ပ္ပ		5+		Teach		me (First, Middle,	Educat		
anc	d a b	Be	17. Father's Neme (First, Middle, Last) Samuel Eugene Lee					Brienne H		"	
Ž	should by	ဥ	19a. Informant's Name/Relationship (Typ.	no Print)	10h Mailin	n Address (Street		ural Route Numbe		State Zin Co	de)
Z	d2 S		Erika Y. Faulk / Da	1.0		7 Jennino		Bowie,			1
e	s 1 end f Heelth Item 27 other tr		20a. Method of Disposition			sition (Name of natory or other place		-	20c. Location - 0		, State
Baltimore,	permit. Peges Department of Important: If Its any Injury or o		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	River	dale	Park Cre	ematory	3/24/05	Riverda	ale, M	D
Bal	Depared important important in suny in suny in suny in suny in suny in suny in sunce.		21. Signature of Funeral Service License		C	Name and Addre nead Fune	ral Lione		achinata	on DC	20011
			23a. Pert1. Enter the diseese, or complic shock, or heart failure. List only on	cations that caused the death.	Do not ente	or the mode of dyir	ig, such es cardia	c or respiratory arr	est,	Ap	proximete erval Between
)	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	_Renal Fail						On	nset end Death
		iner	- b	Bladder Ca		uence of):				i	
oʻ	aath certificete be executed ettending physician end for use es the buriel-trensit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	Due to (or as	a conseq	uence of):					
68760,	ficete be physicial stre bu	Medicai	Ceuse (Disease or injury thet initieted events resulting in death) Lest	Due to (or as	e consequ	uence of):					
Вох	nding use e	2	d.	•							
	o D	SCa	Part II. Other significant conditions cont	ributing to death but not resulting	ng in the un	iderlying cause giv	en in Part I.	23b. Did to	obacco use con	tribute to the	e cause of death?
P.O	thet the	by Physician		pertension				101	es 2 No	3 Probabi	ly 4∏Unknown
Records,	aw requires t is been sign 2 should be	ompleted t						24a. Was a perfor		availal	autopsy findings ble prior to etion of cause th?
	The law ate has t page 2 s	E						1 🗆 Y	es 2√2 No	1 🗆 Y	es 25√1No
Vital		BeC	25. Was case referred to medical				26. Place of De	ath (Check only or			
_	Physician: rthis certific rel director,	To E	examiner? 1 ☐ Yes 21/2 No	ospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatien	1 3□ DOA Oth	er: 4 Nursing I	Home 5 ☐ Reside	ence 6 □Othe	or (Specify)	
n of			27. Menner of Death 1 ☑ Naturel 5 ☐ Pending	28a. Date of Injury (Month, Dey Year) 28	b. Time of Injury	28c. Injui Woo	y et k?	28d. Describe h	ow injury occurre	be	
Sio	Attending or death. actor: After by the fune	catic	2 Accident investigation				Yes 2 □ No				
Division	s efter d	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, larm, stre	et, lactory, office		28f. Location (S City or Town		or Rural Ro	oute Number,
)	To the Hospital or Attendity within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1	ician: To the best of my knowle er: On the basis of examination end manner steted.	dge, death end/or inv	occurred et the tir estigation, in my o	ne, date end place pinion, death occ	e, and due to the curred at the time, d	ause(s) and mar ate and place, a	nner as state ind due to the	d. e cause(s)
′	within To the Comp	M	29b. Signature end title of certifier		e number	2	9d. Date signed	(Month, Dey	r, Year)		
) and	un		D 4	5 2 1	7	March	18, 2	2005
			30. Name end eddress ol person was con		Ba) (Type, I	Print)					
			Aderowale Ajayi,	, M.D. 620	Rd. #U	15 Col	lege P	ark,	MD 20746		
	Sta	te	MAR 2 (Manth 2005 Year)	32. Redistrer's Signature	2						

DHMH 16 Rav 6/95

			1 - For State Registrar	State of	Marylan		artment of F		d Mental Hy	giene Reg. No. 2	105	1001
	Physici /Medic		Decedent's Name (First, Middle PATRICIA L.	, Last) FLETCHER					2. Date of De Month March	Day	Year 2005	3.Time of Death / 9:50 A M
	Examin		4a. Facility Name (If not institution Holy Cross Hos	· .	ber)		4b. City, Town, o Silver		eath	4c. Count	200	У
	Funeral Director		5. Social Security Number 215-38-4930 Usual Residence of Decedent	6. Sex 7 1 ☐ M 2 ☑ F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	Irs. 8. Date of Bir (Month, Da Sept. 1	th ly, Year) 9, 1940	Cour	place (State or Foreign htry) hington,DC
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow any Injury or other traumatic event. The Medical Examinar must be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County	12. Was Deced Armed Ford Armed Ford Armed Ford I 19 es 1f Yes, Give Year or Da 1f Yes, G	Lar lent Ever in U. 205? Aor 5+) tt Spouse 205. P	16a. Deced (Give life. I	Nas Decedent of H 1 Yes, specify Cube 1 Yes 2 No dent's Usual Occup kind of work done DO NOT use retired Binder Garage Address (Street Columbia Stoln (Name of natory or other plac Nat'1 Ceme Name and Addres	Ispanic Origin? an, Mexican, Pu Specify: Istimum of a most of wind or	(Specify Yes or Noterto Rican, etc.) working Name (First, Middle, aret McNau Rural Route Number, Landove Date 28/2005 Gasch's Furenue, Hya	Print Maiden Sumar Ighton er, City or Town, 20c. Location Suitlar Ineral H	What Cour ce - Americ ck, White, fy: Whi usiness/Inc cing me) State, Zip 7 land City or To nd, Ma Home,	can Indian, etc te dustry 20785 own, State aryland P.A.
Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or condition resulting in death) Immediate Cause (Final disease) or conditions Immediate Cause (Final disease) I									Day Year The cause of death? The cause of death?			
	Sta	to	AHMED NA 31. Date filed (Month, Day, Year)	WAZ PO		838/4	Print) Gau	Thers	burg r	00 20	988.	3.
	Registr	-	MAR 2 5 2005	Bean !	K So	wells.						

	1 - State Registrar 1. Decedent's Nam	ne (First, Middle, L	_ast)			rtificate	0, 2			2. Date of D	Reg. No eath			3. Time of Deat
sician edical	Willis		E		oremar)				MAR	CH 3	30,5	XOOS 6	93:35
miner	4a. Facility Name (mber)				Location o	of Death			County of		
ral	5. Social Security N	al Hospita	Sex	7. Age (In yrs	s. last birthday)		1 Year	If Under		8. Date of Bi		llegar		e (State or Fore
	217-18-4 Usual Residence of		1, M 2□F	81	Yrs.	Months	Days	Hours	Min.	8. Date of Bi Month, D Jan 12	2, 19	24	MD	ce (State or Fore
tor	10a. State	10b. County Allega	any	10c. C	City, Town or Lo	ocation perland	d						10d.	Inside City Lim
Funeral Director	10e. Street and Nu					10f. Zip		04500			10g. Cit	tizen of Wh		?
erai	1010 LE	exington A	12. Was Dece	dent Ever in	U.S. 13.	Was Deced		21502 Spanic Orio		ecify Yes or No Rican, etc.)	0-		- American	Indian,
by	1 ☐ Never Marr 3 ☐ W Vidowed	ried 2□ Married 4□Divorced	Armed For 1 ☐ Yes If Yes, Give Year or Da	2 □ No 'e		If Yes, speci 1 ☐ Yes 2		n, Mexican Specify:	, Puerto	Rican, etc.)		Black,	white, etc	
Completed		15. Decedent's acify only highest g	rade completed)		16a, Dece	dent's Usual kind of word DO NOT use	il Occupa rk done d se retired)	ation during most	of worki	ng	16b. K	(ind of Busi		stry
Com	Elementary/Seco	12	College (1	-40/ 5+)	Machi	nist					B&C	O Rail	road	
To Be (17. Father's Name David	(First, Middle, Las	•							(First, Middle (Davis)				
4 9		lame/Relationship Foreman		n	19b. Mailin	ng Address Box 4	(Street a			Ridge	er, City o		tate, Zip Co	V 26753
once. To Be Completed by Funeral Director	20a. Method of Dis			20b.	Place of Dispo	osition (Nam matory or oti	ne of ther place	9)		ate	20c. Lo	ocation - Ci	ity or Town	, State
oi i		5 Other (Spec	city)	Hil	Icrest Me			s of Facility		4/2/2005		ımberl	land	MD
	10	IM	LAN	AMA			arpelli			me, P.A.			4500	
	232 Part Frier t	the diagram		1/0/		108	3 Virai	inia Av	enue	Cumbe	rland	MD 21	1507	
	shock, or hea	art failure. List onl	mplications that ca ly one cause on ea	aused the dea	ath. Do not ent	108 er the mode	3 Virgi	inia Av	enue cardiac o	; Cumbe r respiratory a	rland, irrest,	, MD 2	Ap	oproximate terval Between
	Immediate Cause disease or condition	art failure. List oni (Final on	mplications that ca y one cause on ea	ach line.	ath. Do not ent	108 er the mode	3 Virgi e of dying √∧ ∧	inia Av g, such as d J	enue cardiac o	; Cumbe r respiratory a adrivy	rland, irrest,	, MD 2	Ap	oproximate terval Between nset and Death
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it, r	Immediate Cause disease or condition resulting in death)	(Final on	a G	astro	$0 - j_{\gamma}$ equence of):	108 ter the mode testi	S Virging of dying	inia Av	enue cardiac o	; Cumbe r respiratory a oding	rland,	, MD 21	Ap	terval Between nset and Death
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DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of M	aryland		artmen rtificate					giene Reg. No.	05	12019
	Physici	an	1. Decedent's Name (First, Middle, L	ast)	IDE	Z					2. Date of Dea Month MARCH	Day	Year 2005	3. Time of Death 4:45 PM
	/Medic Examin		4a. Facility Name (If not institution, g				4b. City,	Town, or	Location	of Death	IIIRCVI		inty of Death	
	_Xamii		Hebrew Home of Gre	ater Washing	rton		Ro	ckvi.	11e			Mo	ntgomer	У
	Funeral		Social Security Number 6.		ige (In yrs. las	st birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h v. Year)	9. Birth	plece (State or Foreign
	Director		021-20-5388	1 ☐ M 2 ☐ F	78	Yrs.	Wioritals	Days	riodis		Jan. 27,	1927		achusetts
	p ,		Usuel Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation							10d. Inside City Limits
	anyla shov	٦			Too. Only,									1 ☐ Yes 2 ☐ No
	Ba-f	Director		ntgomery		ROCH	ville 10f.Zip	Cada				10g. Citizen	of What Cou	into/?
	with t		10e. Street and Number 6105 Montrose Roa	nd				0852				Tog. Oitizett	USA	
	18 23	era		12. Was Deceden	t Ever in U.S.	13			spanic Ori	igin? (Sp	ecify Yes or No	- 14. F	Race - Ameri	icen Indian,
36	be filed within 72 hours after deeth with the Maryland rital Hygiene. so other than "natural, or items 23e or 28e-f show event, it a Medical Exactiver must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces 1 12 Yes 2 If Yes, Give Year or Dates	;?] No		If Yes, spec	offy Cuba	n, Mexicar Specify:	n, Puerto	Rican, etc.)		Black, White	
21215-0036	2 hou	ted	15. Decedent's			16a. Dece	dent's Usua	I Occupa	ation			16b. Kind o	f Business/Ir	ndustry
75	nin 72 n n	pie	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-40)	(5+)	life.	kind of wor DO NOT us	nk done d se retired	during mos)	it of work	ing			
21	d within giene. or then "	Completed	Liomonially (o 12)	5+		Res	search	Scien	ntist			Medi	cal Res	earch
pu	al Hygie I other vent, E	Be	17. Father's Name (First, Middle, Las	st)					18. Mothe	er's Name	e (First, Middle,	Maiden Sun	name)	
Jai	ould be i Mental I varked of	2	Max Gidez							Ida	Burgin			
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other trsumstic events.		19a. Informant's Name/Relationship J. Reed Gidez/ So								al Route Numbe , NJ 0764		wn, State, Zi	p Code)
	Heal Heal		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Nan	ne of		March			on - City or T	own, State
uou	ages ant of t: If I		1 ☐ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec				matory or o can Cre		y :	200		Alexand	dria, V	irginia
Baltimore,	artme ortan injur		21. Signature of Funeral Service Lic		1	-					ral Home			
Ba	Depariming Depariment Important in Sunce		1 (inshew	Lole							Silver S		Md 2090	1
	代数		23a. Pert1. Enter the disease, or co shock, or heart failure. List on	p ications that cause	ed the death.	Do not en	ter the mod	e of dyin	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
8	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. HE7	IA ST	ATI Ince of):	CE		-ASI	r Ci	gnit	R		Onset and Death
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	is a conseque		ען ט זיי				1 100			
_	ate be executed only sician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	is a conseque	ence of):		-					-	
8760,	be e. Sician buria													
687	ficate phys	glic	0	d.										
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. if yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal of at time of dea	leath 3	□Ectopic pr □ Other (sp						Date of delive Month	very Day Year
Ο.	res that the igned by be detact	by Ph	Part II. Other significant conditions	contributing to death	but not result	ting in the u	inderlying c	ause give	en in Part I	1.	23e. Did to	obacco use c		the cause of death?
ord	v require been sig should b	eted	P17190113	MELLII	u j	11	PC	4	,		- 4=	Yes 2□No		
I Records,		Completed									24a. Was autop perfo 1 Yes			opsy findings available ompletion of cause of
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11						e of Deat	h (Check only o	ле)		
of	Physician: this certificantal director,	2	1 ☐ Yes 2 No	Hospital: 1 🗆 Inpa		R/Outpatie			4 K N		me 5 Resid			fy)
on C	ding P h. After I	lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Day Year)	28b. Time o Injury	f A	8c. Injun Wor	/at k? Yes 2. ☐		28d. Describe h	now injury oc	curred	
Division	or Atten	Certification	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of I	njury - At hon etc. (Specify)	ne, farm, st			.00		28f. Location (5 City or Tox		umber or Rur	al Route Number,
_	Hospital 24 hours a Funerel I tely filled	Medical Co		Physician: To the beseminer: On the basis	of examination									
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner	7/1	1	290	. Licens	e number			29d. Date sig		
)	F 3 F 8		ha is laim	11 40	alu	y M	.0	D 3	354	36				,2005
	15+1		30. Name and address of person with	o completed cause of	death (Item	23a) (Type,	Prior) I	Barba	ara K	alaz	ny, MjD	./)	204	252
	Sta	ate	31. Date filed (Month, Day, Year)	32. Tegis	strar's Signatu	Ire I	b all	KI	110	0	/		200	1 6
Ţ	Regist		MAR 24	2005	un a	. Also	and I							

			1 - State of Maryland / Dep	artment of Health and Mer rtificate of Death	ntal Hygien	
	Physici	an	1. Decedent's Name (First, Middle, Last)			3. Time of Death
	/Medio	cal	Goldie E. Gardner 4a. Facility Name (If not institution, give street and number)		arch 22	
	Examir	ier	1200 Oak Avenue	4b. City, Town, or Location of Death Shady Side		c. County of Death nne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. 8	Date of Birth	9. Birthplace (State or Foreign
	Director		577-01-2758 1 M 2X F 92 Yrs.	Months Days Hours Min. A	(Month, Day, 1991 ug • 2, 19	12 Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Maryi -1 sho	tor	Maryland Anne Arundel Shad	7 Side		1 ☐ Yes 2 X No
	or 28e	lirec	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	ath wi	rai	1200 Oak Avenue	20674		U.S.A.
	ter de ttems	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ∑ No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	y Yes or No- an, etc.)	 Race - American Indian, Black, White, etc.
93	urs af	þ	3 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: white
2	be filed within 72 hours after death with the Maryland tal Hyglene. d other then "netural", or items 23e or 28e-f show event, ite M. dical Examinar cust be neithed at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of working	16b. I	Kind of Business/Industry
121	within ne. hen	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	+.	elephone company
2	filed with Hygiene other the ent, the A		12 dire	ectory supervisor 18. Mother's Name (Fi		
<u>a</u>	lid be lentai ked o	To Be	Isaac R. Rudacille	Sarah	Fox	
Maryland 21215-0036	les 1 and 2 should be filed w of Health and Mentat Hygier If item 27 is marked other ti or other treumatic event, Its		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ng Address (Street and Number or Rural Ro	oute Number, City	or Town, State, Zip Code)
	and 2 ealth m 27 I			Staples Rd. # 104,		·
Baltimore,	Pages 1 nent of H int: If itel			position (Name of Date matory or other place)		ocation - City or Town, State
				National Cemetery 4 2. Name and Address of Facility	4/11/05 <i>I</i>	Arlington, VA
B	permit. Departr Importe eny inju			Rausch Funeral Home,	P.A., O	wings, MD 20736
н			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or hearthailure. List only one cause on each line.			Approximate Interval Between
. 1	Pnysician ·			scular accident	+	Onset and Death
	/Medical Examiner		resulting in death) a. — Due to (or as a consequence of :	scular accident		
	LAGIIIIICI	7	Sequentially list conditions, b. atrial til	cillation		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury			
oʻ	an and rial-tra		that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8/60	the death certificate be executed y the attending physician and iched for use as the buriat-transit	dicai	d			
٥	ding p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			
ROX	leath certific attending p I for use as	Physician/Me	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
j.	t the d by the ached	hysi	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown	2 0 11 01 (aboutly)		
ις L	law requires that the de as been signed by the 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the t	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ecords,	equire sen si		dementia		1 ☐ Yes 2	□ No 3 □ Probably 4 🖫 Unknown
ပ္ပို	alaw ras be	Completed	hypertension		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E E	sicien: The law s certificate has b irector, page 2 s		colon cancer		performed? 1☐ Yes 2 No	death?
VItal	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death C/		A 5704 5 10 14 1
0	ding Phys h. After this funeral di	Η,	27. Manner of Death 28a. Date of Injury 28b. Time of	1 3 DOX 4 Nulsing Home	Describe how inju	
Ö	ttendin death. tor: Aft the fun	atio	2 Accident investigation	M 1 Yes 2 Yo		
DIVISION	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, st building, etc. (Specify)	eet, factory, office 28f.	Location (Street as City or Town, State	nd Number or Rural Route Number, e)
_	pitel	al Ce	29a. Certifier Certifying Physician: To the best of my knowledge, deal	h assured at the time, data and along and	dua to the accurate	A cod account of the code
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edica	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred a	it the time, date an	d place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and titles conflict	29c. License number	29d. Da	ite signed (Month, Day, Year)
			V Swoas M	D40210		3-24-05
	15		29b. Signature and titled certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Le Slie F. Brooks, MD 13A 0 w 31. Date filed (Month, Day, Year) WAR 2 4 2005	Print) 18m Chille Rd. IND	et Pin	er MD 20 778
	Sta	te	31. Date filed (Month, Day, Year) 32. Registra Signature	10000000	, /-70	
	Registr	ar	MAR 2 4 2005 > Beaux &	Goods		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amend 4a.b.Per Phys.PGC 3-29-05cr Certificate of Death Registra/Amend18.20b.c.Per FH PGC 3-29-05 cr Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 20 Day 2005 8:50 p M George 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Suburban Hespital Holy Cross Hospital Bethesda Silver Spring 8. Date of Birth (Month, Pay, Year) Oct. 27, 1921 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1□M 24 F Libería, WA 577-13-7393 83 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 AYes 2 No Prince Georges Springdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 Liberia 3613 Edwards Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXNo Specify Specify: 3 Widowed 4 Divorced **Black**

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nanny

20b. Place of Disposition (Name of cemetery, crematory or other place)

23a. Part1. Enter the disease, or condication/ that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on type charse on each line.

Toxic Metabolic Encephalopathy

Due to (or as a consequence of):

_{b.}Aspiration Pneumonia

Due to (or as a consequence of):

Due to (or as a consequence of):

unk George Wash Cem

Direct Funeral by Completed 17. Father's Name (First, Middle, Last)

Be

Physician

/Medical

Examiner

Funeral

Director

Doris

10a. State

MD

within 72 hours after death with the Maryland in then "naturel", or Items 23s or 28e-f show the Medical Examiner must be colified at other then permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othe eny injury or other treumetic event, 90ce.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

burial-tran

and the attending physician as use signed by been has this certificate After

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Physicien:

Attending

death. the 1

within 24 hours after d To the Funeral Direct

Director:

in by t

Physician/Medical þ Completed Be 2 Certification: Medical

Examiner

immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Live birth in the past 12 months? 9 Unknown

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

a Sepsis

_cDysphagia

Elementary/Secondary (0-12)

James George

19a. Informant's Name/Relationship (Type, Print)

Jemima B. Cooper/Neice

* 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

6th

20a. Method of Disposition

23c. If yes, outcome of pregnancy 2 Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

Unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

716 Kennedy St. NW Washington, DC 20011

Apr. 9, 05

unknown

3613 Edwards Street Springdale, MD 20774

23d. Date of delivery Month Day

1 Yes

16b. Kind of Business/Industry

20c. Location - City or Town, State

Private

Sarah George

Adelphi, unknown

18. Mother's Name (First, Middle, Maiden Sumame)

22. Name and Address of Facility Johnson and Jenkins Funeral Home

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Approximate Interval Between Onset and Death

Year

Malnutrition Deep Venous Thrombosis of Right Leg 25. Was case referred to medical examiner?

1 Yes 2 No 27. Manner of Death 1XXNatural 5 Pending investigation 2 Accident 3 Suicide

Acute Renal Failure

ertifie

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

М

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 XCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29c. License number

29d. Date signed (Month, Day, Year) March 21, 2005

47867

Zunig

4701 Randolph Rd. #101 Rockville, Maryland 20852

impleted cause of death (Item 23a) (Type, Print)

State Registrar

30. Name and addre

29b. Signature and title of

4 Homicide

29a. Certifier

32. Registrar's Si

-227 S	1	ĺ	State of Maryland / Dep 1- State Unpend Item 23a,27,28a-f per me Registrar	artment of Health and G843 5-3-05 tas rufficate of Death	Mental Hyg	jiene •g. No.? 115 12022
	Physici /Medic		Decedent's Name (First, Middle, Last) LUCIE MARIE	GILBERT	2. Date of Dea Month March 3	th Day Year 3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) 10300 Southard Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Dea Beltsville If Under 1 Year If Under 24 Hrs		4c. County of Death Prince Georges
539,	Funeral Director		220-70-4609 1□ M 2X□ F 47 Yrs.	Months Days Hours Min		9. Birthplace (State or Foreign Country) Montreal, Canada
4	e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George's 10c. City, Town or Le College			10d. Inside City Limits 1 X Yes 2 □ No
	h with the M 3a or 28e-f at be notifie	ai Director	10e. Street and Number 5009 Iroquois Street	10f. Zip Code 20740	1	og. Citizen of What Country? United States
980	be filed within 72 hours after death with the Maryland hat Hygiene. od other than "natural", or items 23a or 28e-1 show event, the Medical Exertirer must be neitlied at	by Funerai	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 【XNo Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	d within 72 ho giene. ir than "natur the Medical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) Ce Clerk	orking	16b. Kind of Business/Industry Janitorial Services
Maryland	B a b	To Be C	17. Father's Name (First, Middle, Last) Guy Gilbert	18. Mother's Na Claire	me (First, Middle, I	Maiden Sumame) Talbot
Mary	s 1 and 2 should f Health and Mer item 27 is marke other treumatic			ng Address (Street and Number or A . Main Street Yac		, City or Town, State, Zip Code) North Carolina 27055
Baltimore,	Pages 1 a nent of Hea nnt: If item ury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition Cells of	matory or other place)		20c. Location - City or Town, State Burtonsville, Maryland
Balti	permit. Pages. Department of P Importent: If ite any injury or of		Noraca UN recured 4	2. Name and Address of Facility Onald V. Borgward 400 Powder Mill R	Road Belts	sville, Maryland 20705
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries	er the mode of dying, such as cardia	c or respiratory arr	est, Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Useca of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
P.O. Box 6	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P	uires that signed b	by	Part II. Dther significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		pacco use contribute to the cause of death?
of Vital Records,	The law require ate has been single 2 should b	Completed			24a. Was a autops perform	v prior to completion of cause of
r Vita	ysicien: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner? 1 XYes 2 No Hospital: 1 Inpatient 2 EP/Outpatier		ath (Check only on	e) Ince 6 Nother (Specify) at scene
on of	ding Ph h. After thi funeral	tion; T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time o	28c. Injury at Work?	28d. Describe ho	w injury occurred
Division	To the Hospitel or Attend within 24 hours after deatl To the Funerel Director: completely filled in by the	Certification:	3 Suicide 4 Homicide Accident Investigation 3-31-05 6:30		28f. Location (St. City or Town	struck by train Test and 10300 PS of Bouthard Dr. Lle, Maryland
	e Hospi 124 hour e Funeri etely fills	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatl and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occ	and due to the ca	ause(s) and manner as stated.
	To th within To th сопр	Me	29b. Signature and title of certifier Therefore M. K. Y.	29c. License number OCME		ed. Date signed (Month, Day, Year) arch 31, 2005
			30. Name and address of person who completed cause of death (Item 23a) (Type, THE UDO RE M. KIM	111 Penn Stree	t Baltin	nore, Maryland 21201
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Carle		

		•	For State Registrer	St	ate of	Maryland		artment of F tificate of				giene	2005	12023
	Physici		Decedent's Name (First, M Lena Fave	iddle, Last) Gonce							2. Date of Dea Month April	2 Day	2005	3. Time of Death 12:45 P M
}	/Medio Examir		4a. Facility Name (If not institu		and numi	ber)	-	4b. City, Town, o	r Location	of Death			County of Dea	
1			Harford Me	morial I	Hospi	tal		Havre d					arford	£
	Funeral Director	2	5. Social Security Number 12–76–7697	6. Sex 1 ☐ M		'. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da) 9/19/58	h y, Year) }	C	rthplace (State or Foreign country) aryland
	and		Usual Residence of Deceden 10a. State 10b. Cou			10c. City,	Town or Lo	cation						10d. Inside City Limits
	Marylan -f show iied at	ξ	MD C	ecil		Pe	erryv	ille						1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number					10f. Zip Code				10g. Citiz	en of What C	country?
	th with		542 Aiken 2	Avenue				2190)3			U	.S.A.	
36	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23a or 28a-f show ent, the Madical Examinat must be notified at	by Funeral	11. Marital Status ↑★Never Married 2☐ 1 3 ☐ Widowed 4 ☐ Divor	Married 1	/as Deced rmed Ford Yes 2 Yes, Give ear or Dat	2 (Vas Decedent of H f Yes, specify Cub: □ Yes 2☑ No	lispanic Or an, Mexica Specify	n, Puerto	ecify Yes or No- Rican, etc.)		4. Race - Am Black, Wh Specify:Wh:	
21215-0036	72 hours "naturel", edicel Exe	ted	15. Dece	dent's Education	1		16a. Deced	lent's Usual Occup	ation				d of Busines:	
215	thin 7 e	Completed	(Specify only his Elementary/Secondary (0-1		ollege (1-4	4or 5+)	life. I	kind of work done OO NOT use retired	d)	st of worki	ng			
21	led wi lygien her th	Co	12	-fl- (0		Mach	ine opera			/ 		o Cor	o .
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Ž	hould d Mer mark metic	2	19a. Informant's Name/Relati		rint)		19h Mailin	g Address (Street			Lena S:			Zin Code)
Ma	th an lith an 27 is riteu		Jeffrey Al		,			1 Cherry						
ē,	s 1 ar f Hea item	200	20a. Method of Disposition			20b. Plac	e of Dispo	sition (Name of	-		ate			r Town, State
9E	Page:		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 R. A. Ferris & Co. 4								5	West	Cheste	er, PA
Baltimore,	permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other treu		21. Signature of uneral Serv	rice Licensee	26	9 11	22	. Name and Addre	ss of Facil					
0,	Physician (Medical Examiner physician and physician and the prival-transit the prival-transit physician and the physicia	Examiner	Tarring-Cargo Fu Aberdeen, Maryla 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									rest,		Approximate Interval Between Onset and Death
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P.O. Box	The law requires that the death certificate has been signed by the attending I	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 4	Live bir	ome of pregnanc th 2 ☐ Fetal de nt at time of deat wn	eath 3	Ectopic pregnancy Other (specify)	/			23	d. Date of de Month	elivery Day Year
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Vita	ician certifi ector	Be	25. Was case referre to mee examiner?	dical Hospit	al.		/	Oth	OF		(Check only o			
of Vital	Phy this	. T	1 Yes 2 No 27. Man r of Death		1 🗀 inj		VOutpatien Bb. Time of		4 🗀 141		ne 5 ☐ Resid 28d. Describe h			ecify)
on	fte fte	tlon	1 Natural 5 ☐ Pe	nding estigation	(Month,	Injury , Day Year)	Injury	28c. Injur Wor M 1	k? Yes 2⊟		200. 200.00	low injury	occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 □Co	uld not be	e. Place o building	of Injury - At home g, etc. (Specify)	e, farm, stre				28f. Location (S City or Tow		Number or R	tural Route Number,
P.S.	the Hospital hin 24 hours a the Funeral t	Medical (29a. Certifier 1 Certi (Check only 2 Medi one)	cal Exeminer: (n: To the b On the bas and manne	sis of examination	edge, death n and/or inv	occurred at the tir restigation, in my o	ne, date ar pinion, dea	nd place, a	and due to the dead at the time, d	ause(s) a date and p	nd manner a lace, and du	s stated. e to the cause(s)
	To the withing To the company of the	Σ.	29b. Signature and title of cert	41th	m	.p.		29c. Licens	6 number			29d. Date	signed (Mon	th, Day, Year)
2			Visup	SIM	7	of death (Item 2:	5	Print) Whoh	PAVI	2	H06	mi)/.	2/078
	Sta Registr		31. Date filed (Month, Day, Y. APR 0	7 2005	32 Rec	gistrar's Signatur	And	de						

			1 - For State Registrar		State of M	aryland / [artment of H <i>rtificate of I</i>		nd Mer		iene	005	12024
	Physici	an	Decedent's Name (First								Date of Deat Month	th Day	Year	3. Time of Death 7:00 P M
	/Medio	al	4a. Facility Name (If not in		Mary Agne:	s Handle	У	4b. City, Town, or	Location of I		larch 2		005 inty of Death	7.00 1 M
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	ס		Usual Residence of Deced			100 Cit. T					tober 2	.4, 192		
	Aaryla f shov	ō		County	1	10c. City, Town							1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-	Director	Maryland Sa 10e. Street and Number	aint Mar	y's	Leona	ardt	10f. Zip Code			1-	0g. Citizen	of What Cour	
	th with 23a o ust be		39608 Lady Ba	altimore	Avenue			2065	0			US	SA	
21215-0036	ges 1 and 2 should be filed within 72 hours efter deeth with the Maryland it of Health and Mental Hygiene. If flem 27 is marked other then "natural", or items 23a or 28a-f show or other treumatic event, its Marical Exertire must be notified.	by Funeral	11. Marital Status 1 ☑ Never Married 2 3 □ Widowed 4 □ Di		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Decedent of Hi fYes, specify Cuba I□Yes 2⊠ No	spanic Origin n, Mexican, F Specify:	n? (Specify Puerto Rica	Yes or No- an, etc.)	14. [Race - Armeno Black, White, ecify: Whit	etc.
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ם 2	e filed Il Hygi other vent, I	Be Co	17. Father's Name (First, A	Middle, Last)			Sec.	letary	18. Mother's	Name (Fi	rst, Middle, M		nion name)	
ylar	ould by Menta arked	ToE	Robert Francis	s Handle	у				Genevi	eve Ce	celia Ga	annon		
Maryland	d 2 sh h and 7 is m treum		19a. Informant's Name/Re		, . ,			g Address (Street a						
	tem 2 tem 2 other		Genevieve Hand] 20a. Method of Disposition		ll / Sister	20b. Place of	Dispos	Lady Baltis	1	enue,] Date			lary land	
m 0	Pages nent of ant: If I		1 🖫 Burial 2 ☐ Cren `4 ☐ Donation 5 ☐ O				y,cren ncis emet	atory or other place Xavier		March 29, 200)5 I	Leonard	ltown, Ma	arvland
Baltimore,	permit. Pages 1 am Department of Heal Importent: if Item 2 any injury or other ance.		21. Signature of Funeral S		inan		22 Mai	Name and Address tingley-Gar	s of Facility rdiner I	unera	L Home.	P.A.		21,1000
			23a. Page . Enter the dise shock, or heart failur	ase, or compl e. List only o	ications that caused ne cause on each li	the death. Do no.	ot ente	er the mode of dying	, such as ca	rdiac or re	spiratory arre	est,		Approximate Interval Between
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.O. Box	requires that the death certif een signed by the attending hould be detached for use as	Physician/M	23b. Was decedent pregnin the past 12 months 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	ant	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)					Date of delive Month	ry Day Year
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Division of	ig Phy ter this neral d	\vdash	27. Manner of Death	Day 6	28a. Date of Injur	y 28b. T		3 DOA 28c. Injury Work	at Nursir		Describe how		Other (Specify curred)
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Σ	of or Attences after death	Certification:		determined	28e. Place of Inju- building, etc	iry - At home, far :. (Specify)	m, stre	et, factory, office			ocation (Str. City or Town,		mber or Rural	Route Number,
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	Sta		William D. Boy 31. Date filed (Month, Day,	Year)	32. Figistra	t lookout l	koad	, Leonardto	wn, Mar	yiand	20650			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registration Property Property 1, 4a, 29c, perMD3/24/05, Property Control Property 1, 4a, 29c, perMD3/24/05, Property Property Property 1, 4a, 29c, perMD3/24/05, Property Pr KATHLEEN HEUNE HANSON 2. Date of Death Month Year **Physician** 21 0152 2005 /Medical Facility Name (If not institution, give street and number)

Yersity of Maryland Medical System 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hunore Year If Under 24 Hrs. If Unde Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 □ M 2 1 X F 462-22-1532 82 Texas Director Jan. 3, 1923 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 11125 Schuylkill Road 20852 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖺 No 21215-0036 Yes Give Specify: Specify: 3 Nidowed 4 Divorced White "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Salesperson Real Estate Injury or other traumatic evant. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Rudolph Heune Elizabeth Gest 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trai Robert Hanson/ Brother-in-law 14100 Quince Orchard Road, North Potomac, MD 20878 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Slate cemetery, crematory or other place) March 24, 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metropolitan Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 2005 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc · Kein Skil 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PPROVED BY METERAL EXAMINER /Medical Due to (or a) a consequence of): **Examiner** Sequentially list conditions, it is a sequentially cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Ś 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, should be 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 **N**o or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X 8 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of In ury (Honth, Lay Year) funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b Time of After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☑ No 2 Accident investigation 5000 9 in by the lace of Injury - At home, farm, street, factory, office building, etc. \(\sum_{\text{speciful}} \) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. determined 4 T Homicide To the Hospitel o within 24 hours aft To the Funerel Di How 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P-19425 3/21/2005 30. Name. and address of person who completed cause of death (Item 23a) (Type, Print) Watering 22 S. Grane STL UMMC 31. Date filed (Month, Day, Year) strar's Signature State

DHMH 17 Rev 1/2001

Registrar

24

2005

State of Maryland Department of Health and Mental Hygiene Amend Item per FH Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Date of Deeth 3. Time of Deeth Year **Physician** March 4:10PM Helene Hill 2005 Marqa /Medical 4b. City. Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner ARFORD If Under 24 Hrs. 8 Date of Birth (Month, Day, 9 / 4 / 21 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□ M 2XF Yrs. East Prussia Director 225-50-3331 83 Usuel Residence of Decedent death with the Merylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other than "naturel", or items 23s or 28s-f sho traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 17 No Funeral Director MD Harford Aberdeen 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 1900 Fletcher Road 21001 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Peges 1 end 2 should be filed within 72 hours efter Depertment of Health end Mentel Hygiene. Importent: if Item 27 is marked other than "naturel; or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White Be Completed by 3 Widowed 4XXDivorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Retail 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Augustina Wilhelmonsky Julius Griefenhofer 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karin Klunk (Daughter) 1900 Fletcher Rd., Aberdeen, Maryland 21001 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 3/30/05 A. Ferris & Co. West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licenses Del Aberdeen, Maryland 21001-3399 Part 1. Enter the disease, or complications that [a] sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examine or Attending Physician: The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien for use es the bune Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? ঠ 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? hes 2XINO 1 ☐ Yes 2 ☐ No 1 WYGE Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ဥ 1 Yes 2 No ursing Home 5 ☐ Residence 6 ☐ Other (Specify) this : After this funeral of 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: A completely filled in by the fu 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted. edical 2 Medical Examiner: On the besis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature, and titl end address of person who completed cause of death (Item 23e) (Type, Print)

Tokhadav 28/ E May h St) Rising Sun, MS 30. Name Mi Tokhadar 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Marga

			For State Registrar	State of Maryland		artment of H			ene 2005	12027
	Physicia	an a	1. Decedent's Name (First, Middle, Last) Raymond		Har	ris		2. Date of Death Month March 1	9 ^{Day} 200 ^{Ygar}	3. Time of Death
	/Medic	al	4a. Fecility Name (If not institution, give str	eet and number)		4b. City, Town, or			4c. County of Death	
	Examili		2115 Adelina Ro		a bringbrule . ()	Prin If Under 1 Year	ce Fred	erick 8. Date of Birth	Calve	ert place (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. las		Months Days	Hours Min.	July 17	ear Cou	ryland
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Lo	cation				10d. Inside City Limits
	e Mary	ctor	Maryland Calver	t	F	rince F	rederio		0101	1 ☐ Yes 2 ☐ No
	with th	i Directo	10e. Street and Number 2115 Adelina Ro	ad		10f. Zip Code 20	678	109	g. Citizen of What Cou USA	intry :
36	be filed within 72 hours after deeth with the Maryland lat Hygiene. d other then "natural", or iteme 23a or 28a-f ehow event, the Medical Exertinal must be truffied at	by Funeral	11. Marital Status 12 Married 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1960 1 [XYes 2 No If Yes, Give 1962	_ 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: B	, etc.
215-0036	hin 72 hou e. en "natura Medicel E	Completed	15. Decedent's Educa (Specify only highest grade		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wor	king	Sb. Kind of Business/I Labor Un:	
ind 2121	ed ital	Be	12 17. Father's Name (First, Middle, Last) Hamilton	Parran,	Sr.	Manager	18. Mother's Nar Cather	ne (First, Middle, Ma	niden Sumame) Harris	
Maryland	s 1 and 2 should be i Health and Mental item 27 is marked o other fraumatic eve	T ₀	19a. Informant's Name/Relationship (Type Rosalie B. Harri	o, Print)	19b. Mailie				City or Town, State, Z rederick	
	Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rei	20b. Plac	ce of Dispo	esition (Name of matory or other place namVet.C	(e)	Date 20	Cheltenh	Fown, State
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		*4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee				1		neral Hon	
×	, h		23a. Part1. Enter the disease, or complicion shock, or heart failure. List only one	ations that caused the death.		ter the mode of dyin	g, such as cardia	or respiratory arres	it,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	ince of):	Grugoto	phic C	ated S	clerosic	
	Examiner	- G	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	nce of):					
	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):					
8760,	icate be executed physicien and s the burial-transit	lical Ex	d.							
.O. Box 68	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea	leath 3	Ectopic pregnancy Other (specify)	1		23d. Date of deli Month	very Day Year
٥.	signed by d be detac	by	Part II. Other significant conditions cont	nbuting to death but not result	ing in the u	inderlying cause giv	en in Part I.		cco use contribute to	
Records,	he law requir e has been s age 2 should	Completed						24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
Vital	ician: Th certificete rector, pag	Be C	25. Was case referred to medical examiner?	and.		Oth	00 4	ath Check on one		
of	ing Phys	tion: To	1 Yes 2 No 27. Manner of Death Note that I was a second of Death		R/Outpatie 28b. Time o Injury	of 28c. Injur	4 (140/3/119 1	28d. Describe how	ce 6 Other (Spec	cify)
Division	if or Attending after death. I Director: Afte d in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, st	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical C	29a. Certifier (Check only one) To Certifying Physical Examin	cian: To the best of my know. er: On the basis of examination and manner stated.	ledge, dea on and/or in	th occurred at the tire tire tire to the tire tire to the tire to	ne, date and plac pinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of regions			29c. Licens	e number	29	d. Date signed (Monti	n/Day, Year)
)			· (fy	npleted cause of death (Item 2	23a) /Tua-	Print) Day	d (30)	lating	1.D	03
	10+1		30. Name and address of person who con	HOSDIFEL D.	1,0	mite	3/0 /	ince #	redesth	-, MD
ı	St Regist	ate rar	31. Date filed (Month, Cay, Year) MAR 2 3	32. Registra s Signatu		South	,			

13			1 - For State Registrar		arylar	nd / Dep <i>Ce</i>	artment of I rtificate of	Health ar Death	nd Mental H	ygieñ Reg. No	and the state	12028
	Physic /Medi		Decedent's Name (First, Middle, La JOSEPH L.	HAWKINS					2. Date of I Month March 2	Da		3. Time of Death 3:15PM M
	Examii	ner	4a. Facility Name (If not institution, giv 701 Glenwood Stre				4b. City, Town, Annapo		Death		County of Deat nne Arunde	
	Funeral Director		220 32 3121		e (In yrs. 67	last birthday Yrs.	Months Days		Hrs. 8. Date of 8 (Month, 1 May 6,		9. Birti Co. MD	nplace (State or Foreign untry)
	e Maryland 8a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Anne Arus	ndel		ty, Town or L hian	ocation					10d. Inside City Limits X Yes 2 □ No
	h with th	al Dire	10e. Street and Number 1250 Marlboro Road	i			10f. Zip Code 20711			10g. Ci	tizen of What Co	untry?
020	d 2 should be filed within 72 hours after death with the Maryland it and Mental Hyglene. It is marked other than "natural", or itams 23e or 28e-1 show traumatic event, it's Modell Examilier must be notified at	by Funeral Director	11. Marital Status 1 □X Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2(1) If Yes, Give Year or Dates:		.S. 13.		Hispanic Originan, Mexican, I	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Amer Black, White Specify: Bla	e, etc.
0500-6171	within 72 ho ene. than "natur ne Moulcal I	Completed	15. Decedent's El (Specify only highest gra Elementary/Secondary (0·12)	ducation ide completed) College (1-4or 5	+)	(Give	dent's Usual Occup a kind of work done DO NOT use retire Driver	oation during most o d)	f working		ind of Business/l	
Maryland 21	uld be filed fental Hygi rkad other tic avent, I	To Be Co	17. Father's Name (First, Middle, Last, Vanderbilt Hawkii			11401	211,01		s Name <i>(First, Midd</i> e Barnes			.abery
	1 and 2 shou Health and M am 27 is man other trauma		19a. Informant's Name/Relationship (Mary E. Tanner/Sis	**		701 (Glenwood	St. #80	or Rural Route Num 08 Annapo	-		
ballimore,	permit. Pages 1 and Department of Healt Important: If itam 2 any injury or other: <u>once.</u>		20a. Method of Disposition 1 ♣ Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specification of Funeral Service Licent of Funeral Service Lice	1)	Ceda	ar Hill		3/ ss of Facility	Date 25/2005 Cedar Hill re. Suitland	Suit] Funera		
	Physician physician /Medical Examiner physician and physician and street the principle of the physician ph	edical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each iir	ie. i C a consequa consequ	Lung uence of):	ter the mode of dyi		rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death 4 mos.
	± 00 €	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal	Ideath 3	Ectopic pregnance Other (specify)	,			23d. Date ot deliv Month	rery Day Year
1 (20 00)	requires that the	by P	Part II. Other significant conditions c	ontributing to death bu	it not resu	ulting in the u	nderlying cause giv	en in Part I.				the cause of death?
2011	: The law re cate has bee ; page 2 sho	Completed								opsy formed?	prior to co	opsy findings available impletion of cause of
TO HOLD IN	To the Hospital or Attanding Physician: The law requires that the death cerwithin 24 hours after death certaint 26 their safter death. To the Luneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injur (Month, Day	Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor M 1 🗀	er: 4 □ Nursi	28f. Location	idence how injur	y occurred d Number or Run	Ress Sisters
3	Hospital c 24 hours af Funeral D stely filled in	edical Cer	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of iner: On the basis of	f my knov	wledge, deat	n occurred at the tir	ne, date and p	lace, and due to the	Called(e)	and manner as s	stated. o the cause(s)
1	11	Mec	29b. Signature and title of pertifier	and manner sta			29c. Licens D995		1		e signed <i>(Month,</i> 23/2005	
100	Sta Registr	100	30. Name and address of perso of Sharon Messick 31. Date filed (Month, Day, Year) MAR 2 4 2005		O A	dmira		ane Di	r. Annap	olis	s, MD 2	1401
OHN	H 17 Rev 1/20			SENT OF	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 3:15 A 23 2005 BERNICE MAY HOLDERNESS March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Edgewater

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct. 26, Mellenium Nursing Home Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Pennsylvania 85 Director 162-14-7736 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County ?7 is marked other than "natural", or items 23s or 28s-f ahow traumatic event, the Modical Exercipar mast be notified at 1X Yes 2 No by Funeral Director Prince George's Hvattsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 5908 Jefferson Street 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: Specify: ff Yes, Give Year or Dates: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene.
Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Rolling Pin Bakery Sales/Baker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alma Powell Frederick Pesch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10641 Susquehana Ave., Waynesboro, PA 17268 Ronald Holderness, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ' 4 □ Donation 5 □ Other (Specify) 3/29/2005 | Brentwood, Maryland Fort Lincoln Cemetery 21. Signature of Funeral Service Alcenses 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final 5 minutes **Physician** ardiac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Candio Vascular disease theroscienotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9☐ Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Syndrome 1 Yes 2 No 3 Probably 4 Dunknown Sinus 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Ceremovasuba accident 24a. Was an autopsy performed Hypothyroidism. 1 Yes 2 4 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title7of certifier 3-24.2005 ourona D 50653 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C. SURANA 20751 5851-Deale Churchton Road Deale 31. Date filed (Month, Day, Year)
MAR 2.5 2005 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 12:58 A 21 2005 March CHRISTINE DOROTHY HENRICK /Medical 4c. County of Oeath 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Silver Spring

If Under 1 Year If Under 24 Hrs. | 8. Oate of Birth (Month, Day, Year)

May 4, 1926 Montgomery Fairland Rehabilitation Center 9. Birthplace (State or Foreign Country) Detroit, MI 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2X□ F Director 78 368**-**20-5170 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examinat must be notified at 1 Yes 2 □ No Director Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number USA 2101 Fairland Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Banking Head Bank Teller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Smolark ٩ John Niemiec 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 4700 Yates Road, Beltsville, Maryland 20705 Joanne Rozyczko, Daughter 20c. Location - City or Town, Stete 20b. Place of Oisposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 3/24/2005 Brentwood, Maryland Fort Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland africul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Accident Cerebrovascular /Medical Oue to (or as a consequence of): **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ysician and e burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending physic for use as the b 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year been signed by the atte should be detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Congestive Heart Failure Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2X No 25. Was case referred to medical examiner? After this certification Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ↑ Inpatient 2 ER/Outpatient 3 DOA r 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Oeath Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di t 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0061096 21/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8609 Second Avenue, Silver Spring, Maryland Usha Gollapalli, 32. Registrar's Signature State Registrar

				partment of Health and Mertificate of Death		giene	5 10000
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Mija Marie Jakobowski	1	2. Date of Dea Month March	100	3. Time of Death 4- 11:45A M
	Examir		4a. Facility Name (If not institution, give street and number) Casey House	4b. City, Town, or Location of Death Rockville If Under 1 Year If Under 24 Hrs.		4c. County of De Montgome	ery
	Funeral Director		5. Social Security Number 573-29-8414 Usual Residence of Decedent 6. Sex 1 M 2 T F 7. Age (In yrs. last birthday 49 Yrs.	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day NOV • 4	Year)	lirthplace (State or Foreign Country) Drea
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "neturel", or Items 23a or 28e-1 show imatic event, It a Modical Extraple at treast tennillised at	rector	Maryland Montgomery Ashton	ocation 10f. Zip Code		log. Citizen of What (10d. Inside City Limits 1 ☐ Yes 🛣 No
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9800	nours after urel', or ite	þ	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)	Specify: As	nite, etc.
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Maryland 21215-0036		To Be C	17. Father's Name (First, Middle, Last) John E. Allen	18. Mother's Name Joyce L.	e (First, Middle, I		
	is 1 and 2 should of Health and Men item 27 is marke other treumatic		A. Jeff Jakobowski/husband 1770	ing Address (Street and Number or Rura 5 Crystal Spring T	errace A	Ashton, MD	20861
Baltimore,	Page nent c ent: If ury or		'4 Donation 5 Other (Specify) W. Arund	el Crematory 20	h 28,	20c. Location - City of Odenton, M	aryland
n D	permit. Departr Importe eny inji		Bevely L. Hatte MO1251 B 23a. Part1. Enter the disease, or complications that caused the death. Do not er	12. Name and Address of Facility Oing Home Cremation everly L. Heckrott nter the mode of dying, such as cardiac of	e, P.A.	Clarksvil	1e, MD 21029
	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Breast Cancer Due to (or as a consequence of):				Interval Between Onset and Death
ŀ.	icate be executed by physician and burial-transit b	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
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	To the I	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Mon	th, Day, Year)
2	-		30. Name and address of person who completed cause of death (Item 23a) (Type,			March 26,	2005
	Sta Registr		Joseph Kaplan M.D. 6001 Muncaster Mi. 31. Date filed (Month, Day, Year) MAR 2 8 2005 32. Refistrar's Signature	-	MD 20855)	

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1	ls and		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	l Route Numb	er, City or	Town, S	itate, Zi	Code)	
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29b. Signature and title of certifier MD DB096 3.29-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RATENATE S. G. W 24025, TIMEL WILL PD HOWYWOOD MD 26636	e Funeral	Sal	(Check only 2 Medical E	vernings: On the he	seie of avamination	n and/or in	vactination	in my or	ninina das	th occurr	ad at the time	data and	nlaca ar	ad dup t	a the cause/s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RATENET S. G. W 24025, THICK WILL PD 1404400D MD 20636	Total	Me	29b. Signature and title of certifier	/	\sim	15	290	. License	309	6		29d. Date	signed	(Month,	Day, Year)	
1 1 1 1 D(1 V 1 V) = U	10		30. Name and address of person w	tho completed cause	e of death (Item 2 V Mo	3a) (Type,	Print)	N	TCH.	アフ	14000	WOO	D	MD	20636	

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<u>ta</u>	ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?					26. Place	of Death (Ch	neck only o	ne)			
7	Physic this co	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient		-	DOA Othe	4 Nu				6 ☐Other (Sp	ecify)	
n C	ding Ph h. After th funeral	ion;	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	'ea <i>r)</i> 28b. 1	Time of Injury	28c. Injury Work			Describe h	how inju	ry occurred		
Sic	r Attend er death rector: , by the f	icat	2 Accident investigation 3 Suicide 6 Could not be		. At home fa	M erm street fa		Yes 2 □ i	-	Location (Stroot a	nd Number or	Rural Route Number.	
2	after Direct In by	Certification;	4 ☐ Homicide determined	building, etc. ((Specify)	, 311001, 16	iotory, billos			City or Tov			ibiai i loato i vamoui,	
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C		ysician: To the best of r hiner: On the basis of ex and manner state	xamination an									
	o the	Mec	29b. Signature and title of certifier	41.4 manifol 3(d)			29c. License	e number			29d. Da	ate signed (Mo	nth, Day, Year)	
	- 5 + ö		Detay 1	M.D.			D57	795	2_		Š	123	12005	
	3 mp		30. Name and address of person who a	completed cause of dea 106 Military 32. Projectors	th (Item 23a)	(Type, Print) # 50				MD	2/8			
	Sta	te		32. Pogistrar's	s Signature	1	Ar .							
	Registi		31. Date filed (Month, Day, Year) MAR 2 5 2	1005	U D.	1000	CL)							

			For State Registrar	State	of Maryland	•	artmen rtificate			and Me	-	giene Reg. No	フロロに	12035)
	Physici	an	1. Decedent's Name (First, Midd	le, Last)							2. Date of De Month	ath Day	/ Year	3. Time of Death	
	/Medic	cal	Ann C.				4h Cih.	Yau	Lander		arch 2		2005	10:15 A M	
	Examin	ner	4a. Facility Name (If not institution Shady Grove A	-	•		Rock		Location of	of Death			County of Deal		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la:	st birthday)	If Under Months		If Under:	24 Hrs.	8. Date of Bir (Month, Da	th	ontgome 9. Bin	thplace (State or Foreign ountry)	,
	Director		577-36-5303	1□M XX F	76	Yrs.	Months	Days	riodis				28 Wash	ington, DC	
	fand ow		Usual Residence of Decedent 10a. State 10b. County	,	10c. City,	Town or Lo	cation		-					10d. Inside City Limits	
	Many B-f sh	tor	Maryland Montg	omerv	Roc	kvil]	e							1 ☐ Yes 2√XNo	
	ith the	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What Co	ountry?	
	s 23a	rail	1235 Potomac		adcedent Ever in U.S.	10		0850		ning (Cana	it. Van aa Na		U.S.A. 14. Race - Ame	rices la dias	_
' O	ritam ritam	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Amed F	Forces? 2 ∑ No					, Puerto R	cify Yes or No lican, etc.)	,-	Black, Whit		
903	d within 72 hours after death with the Maryland Jiene. I than "natural", or Itams 23e or 28e-f show The Medical Evantiner must be redified at	by	3 ₩ Widowed 4 Divorce		elve		1 ☐ Yes a	Y No	Specify:				Specify: wh	nite	
15-("natu	Completed		nt's Education est grade completed	0	(Give	dent's Usua kind of wor DO NOT us	k done o	furing most	of working	g	16b. K	ind of Business	/Industry	
12	within liene.	dmo	Elementary/Secondary (0-12) 1 2	College	(1-4or 5+)	me. Secret		e remed	,			Dom	t. of I) o C = = = =	
br	otha ant,	Be C	17. Father's Name (First, Middle	Last)		CCLE	ary		18. Mothe	r's Name	(First, Middle			Jerense	_
ylaı	should be ind Menta i marked umatic ev	ToE	Walter Whitney								ction				
Maryland 21215-0036	id 2 sho lth and 27 Is m traum		19a. Informant's Name/Relation		- 1								r Town, State, 2		
	1 ar Hea Hea em		Alan E. Jenkin: 20a. Method of Disposition	s/Son	20b. Pla	ce of Dispo	Brand sition (Nan	ne of		ne			MD 218 ocation - City or		_
Baltimore,	Pages nent of int: If it		XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3		n State	netery, crei Tinc	-		1	3/25/	2005	Bran	twood,	MO	
alti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Licen e	1010	22	2. Name an	d Addres	s of Facilit	Fort	Linco	1n F	uneral	Home	
	90F 9		Jan P.	The		34	01 B1	ader	sburg	g Rd.	Brent	wood	, Md 20	722	
г			23a. Party Enter the disease, of shock, or heart failure. List Immediate Cause (Final	r Mplications that t only one cause on	caused the death. each line.	Do not ent	er the mod	-						Approximate Interval Between Onset and Death	
	Enysician /Medical		disease or condition resulting in death)	a	ASPIK o (or as a conseque	LTA	2~	P	NEU	MO	WIF	١		1 day	
п	Examiner		Occupation for the second second	, Duc	7 (5) 43 4 551136446	1100 01).								•	
	D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conseque	nce of):									
	be executed iclan and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a conseque	ince of):									_
8760,	cate be executed physician and the burial-transit	ledicai E		d											
9	death certificate e attending phys d for use as the	Medi	IF FEMALE:	1	70			_	-						
Вох	eath certific attending p	lan/I	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregnand birth 2 ☐ Fetal d	leath 3	Ectopic pr					1	23d. Date of del Month	livery Day Year	
o.		Physician/M	1 □ Yes 2 No 9 □ Unknown	9□ Unk	gnant at time of dea nown	ım 5L	Other (sp	эспу)							
s, P	es that the igned by th be detache	by Pl	Part II. Other significant condit	ons contributing to	death but not result	ing in the u	nderlying ca	ause grve	en in Part I.		23e. Did t	obacco u	ise contribute to	the cause of death?	
ord	w requires been sign should be										10	Yes 2	No 3□Pr	obably 4 Unknown	
of Vital Record	aw is b	ompieted									24a. Was autop		24b. Were au prior to death?	itopsy findings available completion of cause of	
alF	Th ate pag	e Col	25. Was case referred to medical								1 ☐ Yes	2 No		2 □ No	
Ξ		0 8	examiner?	Hospital:	Inpatient 2 El	R/Outpatier	ıt 3□ DO	A Othe	200		<i>(Check only o</i> e 5 ☐ Resi		6 □Other (Spe	cifv)	
0 0	ding Phys h. After this funeral di	Ju: T	27. Manner of Death 1 Natural 5 Pendi	28a. Date		8b. Time o		Bc. Injury Work	at	-	d. Describe			,	1
Division	Attending r death. actor: After by the fune	ertification:		igation not be	a at talian . At hom		M		Yes 2□1		Of Leasting /	Ctroot or	of Marine and Ch	um l Davida Alivanha	
Div	무용분드	ertif	4 Homicide determ	nined 286. Flat build	ce of Injury - At hom ding, etc. (Specify)	ie, iaimi, su	eel, ractory	, опісе		20	City or To			ural Route Number,	
	Hospital (24 hours a Funeral Distely filled i	calc	29a. Certifier Certifyi	ng Physicien: To the	ne best of my knowl	edge, deat	occurred :	at the tim	e, date and	d place, ar	nd due to the	cause(s)	and manner as	s stated.	_
	within 24 Within 24 To the F complete	Medical	one)	and ma	nner stated.				number				e signed (Monti		
}	N W		29b. Signature and title of certific		mo								-		
لانه	WO		30. Name and address of persor	who completed car		23a) (Type,	Print)	- 36		-			-1 -1	,2005 kuilt, MD	
7	Sta	10	Matthew A	offen10	H MD Registrar's Signatu	9 ·	201	Me	dica	1 (2	nter	live	Rock	kuilt, MO	-
	Registr		MAR 2 4 2	005	Registrar's Signatu	Apra	W								

204	1- For Unpend Item 23a&27 per me G842 4-11-05 tas Certificate of Death Reg. No. 2 3
Physician /Medical	1. Decedent's Name (First, Middle, Last) Horace Johnson 2. Date of Death Month Day Year MARCH 28, 2005 1243
Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death PRINCE GEORGES 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1f Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreit)
urs after death with the Maryland dit, or items 23a or 28e-f show are trust be neithed at by Funeral Director	579-56-3852 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit
	MarylandPrince GeorgeBowie1X Yes 2 □ N10e. Street and Number10f. Zip Code10g. Citizen of What Country?16010 Excalibur Rd.20716United States
	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Yes, Give 1 Yes of No-lif Yes, specify: Black 16. Race - American Indian, Black, White, etc. 17. Yes 2 No Specify: Black
ed within 72 hou ygiene. Per than "nature" 1, the Medical E	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Metropolitan PoliceD
2 should be filed within and Mental Hygiene ie marked other than eumatic event, than To Be Comp	17. Father's Name (First, Middle, Last) Clarence Johnson Mary Jane Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code)
is 1 and 2 sh of Health and item 27 le m other treum	Leslie Mercer/Daughter 11593 North Shore Drive; Reston, VA. 20190 #11 20a. Method of Disposition (Name of Disposi
permit. Pages 1 and Department of Healt Importent: if item 2 any injury or other once.	1
Physician /Medical Examiner	23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of): Due to (or as a consequence of):
cate be executed obly sician and the burial-transit dical Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):
that the death certificate ted by the attending physicated for use as the yelached for the yelach	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
es ti igne be c	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown
Attending Physicien: The death. Ictor: After this certificate hy the funeral director, page fication; To Be Com	24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)
	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 28d. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred
	3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospitel or John To the Hospitel or within 24 hours after To the Funeral Direct completely filled in E Medical Certi	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAROL HALLAW and 111 Penn Street Baltimore, Maryland 21201
State Registrar	31. Date filed (Month, Day, Year) APR 0 4 2005 APR 0 4 2005

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Physician Year Bernard C. Johnson 10:48p M March 18,2005 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Hospital Cheverly Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** Days 1 XM 2 ☐ F Hours Yrs Director 577**-**01-9500 November 21,1910 Wash DC Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is markad other than "natural", or itams 23a or 28a-1 show other traumatic event, the M-cical Examiner must be mained at MD 1 Yes 2 No Directo Landover, MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 973 Central Hills Lane 20785 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itar any injury or other traumatic event, the Medical Even 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 XNo Specify: Black 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Detective MPD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Johnson Annie West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Douglas/Daughter 973 Central Hills Lane, Landover, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cem 3-23-05 Washington DC 21 Signetur of Funeral Service Licensee 22. Name and Address of Facility
Alexander S. Pope Funeral Home 2617 Penn. Ave S.E. Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Cardiogenic Shock Sequentially list conditions, if my leading immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Renal Failure resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical Electrolyte Abnormality IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has performed Division of Vital 1 🗌 Yes 2**X** No 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDWARDS CHEVERLY, MD 20185 ALLISON K. 3001 31. Date filed (Month, Day, Year) MAR 2 5 2005 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 20 2005 Willie Jackson March 3:05 am M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Hyattsville Heartland Healthcare Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1☑M 2□F Yrs. 1919 South Carolina Director 247-32-5126 25 85 Usual Residence of Decedent 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1K Yes 2 □ No Completed by Funeral Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 238 20017 5018 Sargent Rd NE filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced **Black** "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Sanitation Engineer 6th Pagas 1 and 2 should be filed v tment of Health and Mental Hygie tant: If Item 27 Is marked other t jury or other treumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hattie Jackson ပ္ Ollie Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice A. Jackson/ Daughter 6902 Aquamarine Court Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State parmit. Paga Department of Important: If any injury or once. `4 □ Donayidn 5 □ Other (Specify) Harmony Memorial Pk. March26,2005 Landover, MD 21. Signatu e Funeral Service Le Insee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Myocardial Infarction Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inniediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ad by the a 9 Unknown signad to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by Approx. 1-2 wks s/p Limb Amputation 1 Yes 2 No 3 Probably 4 Unknown should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Periphral Vascular Disease 24a. Was an 2 🛛 No certificate 1 Yes of Vital 25. Was case referred to medical 26. Place of Death_(Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division Hospitel or Attending 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e 29a. Certifier 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier anuce 30. Name and address person who completed cause of death (Item 23a) (Type, Print) 6500 Riggs Road Hyattsville, Maryland 20783 Eunice Shakin, MD MAR 2 5 2005 State Registrar

-2319	4	State of Maryland / Department of Health ar State Amend Item 1&Unpend Item 23a, pt 11,27 per me 68	nd Men	tal Hygi	ene	10010
,		Registrar 1. Decedent's Name (First, Middle, Last)		Re-		12040
Physician	n	LLOYD WILLIAM KOCH, II		Month oril 2.	Day Year	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D)III <u>4</u> ,	4c. County of Death	<u> </u>
		221 McKay Road Stevensville			Queen Anne	e's
Funeral			Min. (Date of Birth Month, Day,	Year) Col	nplace (State or Foreign untry)
Director		216-60-5008 53 Yrs. Usual Residence of Decedent	FE	B. 13,	1952 KY	
show	_ [10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
vith the Mar nor 28e-f st be notified	200	MD QUEEN ANNE'S STEVENSVILLE				1 ☐ Yes 2 💥 No
with th		10e. Street and Number 10f. Zip Code 221 MCKAY ROAD 21666		10	g. Citizen of What Cor	untry?
tier death w ritems 23a	era	11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	n? (Specify	Yes or No-	USA 14. Race - Amer	ican Indian,
nd 21215-0036 be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural; or items 23s or 28s-f show event, the Medical Examinat must be notified at	by ru	Armed Forces? If Yes, specify Cuban, Mexican, F 1 Never Married 2 Narried	Puerto Rica	n, etc.)	Black, White	o, etc. HITE
21215-0036 do within 72 hours at giene. Institutal; or or than "natural; or the Medical Evant.		15. Decedent's Education 16a. Decedent's Usual Occupation	of warding	1	6b. Kind of Business/l	ndustry
1215-0 within 72 hu within 72 hu than "natu	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of life. DO NOT use retired)	or working			
nd 21%		12 2 REGISTERED NURSE 17. Father's Name (First, Middle, Last) 18. Mother's	e Name /Fi		MEDICAL laiden Sumame)	
	o ge			WATERM		
re, Marylar s 1 and 2 should be if Health and Monta in marked other treumstice.	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of				ip Code)
- c = n -		DEBRA KOCH/WIFE 221 MCKAY ROAD, STE	VENSV	ILLE,	MD 21666	
0 00-		20a. Method of Disposition 1	Date	2	Oc. Location - City or 1	Town, State
Baltima permit. Pag Department important: any injury c	-	*4 □Donation 5 □Other (Specify) STEVENSVILLE CEMETERY 04			STEVENSVIL	
Baltime permit. Pag Department important: I any injury o		21. Signal to of Furreral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENB 106 SHAMROCK ROA	SEIN & D, CH	NEWNA ESTER,	M FUNERAL MD 21619	HOME, P.A.
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on paich line.	ardiac or res	spiratory arres	st,	Approximate Interval Between
fnysician		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Card resulting in death)	diova	scular	Disease	Onset and Death
/Medical Examiner	1	Due to (or as a consequence of):				
23/14/10		Sequentially list conditions, b. Due to (or as a consequence of):				
cuted od ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events				
760, e be execute rsician and e burial-tran		resulting in death) Last Due to (or as a consequence of):		_		
(8760, cate be ex physician at the burial Exercise Exerci	alca	d				
Box 6 (leath certific attending p	VMe	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	/en/
Vision of Vital Records, P.O. Box 68760, Attending Physicien: The law requires that the death certificate be executed or death. The death. The thin certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit director. The Reformulated by Dhysician Maddical Examples	Physician/Medical	230. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			Month	Day Year
by P.O. s that the ned by the s detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did toba	acco use contribute to	the cause of death?
cords, wrequires been sign should be	9	Cocaine use		1 🗌 Yes	s 2 No 3 Pro	bably 4 Unknown
eco law re as bec	plet			24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
The The page	Completed by			perform	ed? death? XNo 1 ☐ Yes	
f Vital Records, ysicien: The law requires to serrificate has been signed director, page 2 should be of the Completed by	e R			neck only one		
Phys rethis		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at			nce 6 Nother (Spec	ify) at scene
Division of a standing land of the death. In breeter: Aler lin by the funer	Certification:	1 X Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			,,	
Divisio or Attendi after death. Director: A	0	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Stre	eet and Number or Rui	ral Route Number,
Division of the control of the contr		Saliding, ser (Speeding)				
DIVI	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and o occurred a	due to the cat t the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
To the within To the comp	Ž	29b. Signature and fittly of cert fier 29c. License number	-		d. Date signed (Month	
		OCME OCME		A	pril 2, 200)5
COKK		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Z. HOGAM 111 Penn Str	reet	Baltim	ore, Maryl	and 21201
State Registra		31. Date filed (Month, Day, Year) APR - 5 2005 Secure & April 1988				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item#1, per PHY (843,5/3/05) Control of Health and Mental Hygiene

1- For Amend Item#8, per FH, 6843,5/3/05 Certificate of Death

1- Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month 9:50 AM **Physician** KI KIM 05 JIN MA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth 2/25/5 B. Birthplace (State or Foreign (Month, Day, Year) Baltimore
If Under 1 Year If Under 24 Hrs.

Baltimore Min. Medical Center nercu 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Months 1 M 2 □ F sonea Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b County 10a, State r than "natural", or items 23a or 28e-f ehow the Medical Examinar must be indified at 1 Yes 2 No Battimore Dattimore MD Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 31918 2001 Man land Act. 2K KOREA Avenue filed within 72 hours after death Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ €o Baltimore, Maryland 21215-0036 Specify Specify: ASIAM þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. none non 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Sae Dick 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 le any injury or other tree once. GA 54 Secul Sook 3 L.G. AFT 103 1903 Korea Suter Kim Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Va 4 □ Donation 5 □ Other (Specify) 3/25/5 Metropolitary Cremetry 22. Name and Address of Famility CHARLES HIWDS FOWERAL SERV. 21. Signature of Funeral Service Marlboro DR MB 2077 2 12303 KRYAK UPPer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw UNG CANCER Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 1 sate has been signed by the a page 2 should be detached in 9 Unknown 9 Unknow à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 4 Onknown 1 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes certificate the Hospitel or Attending Physician: 26. Place of Death Check onl one funeral director, 25. Was case referred to medical examiner Other: Hospital: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 70 1 ☐ Yes 2 ☐ No 1 Inpatient this 28c. Injury at Work? 28d. Describe how injury occurred Date of Injury 28b. Time of 27. Manner of Death Certification: Injury (Month, Day Year) 5 Pending investigation Natural 1 🗌 Yes 2 No death. 2 Accident after death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours a To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) BAOTMONE MO 21202 301 32. Registrar's Signa State 25 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For Stata Registra Certificate of Death Rag. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician Kneisley Charles Richard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner iumberiar If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1₽M 2□F 577-28-4902 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a M. Jose Exprints In List to prefere 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland MD Director 1√ Yes 2 No 10g. Citizen of Whal Country? 10e. Street and Number 10f. Zip Code 14410 N. Bel Air Dr. SW 21502 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1√Yes 2 No If Yes, Give WWII Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Chessie System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Pauline Collier Kneislev Charles Cleveland Kneisley 19a. Informant's Name/Relationship (Type, Print) Marylee Kneisley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14410 N. Bel Air Dr. SW Cumberland MD 21502 wife 20b. Place of Disposition (Name of cametery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State cometery, crematory or other place) Scarpelli Funeral Home, PA 1 Burial 2 Cremation 3 Removal from State 4/4/2005 MD Cresaptown 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ^{22. Nam}Scarpellis Funellal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23d. Part1. Eyer the disease, or complications that caused the death. shock, y heart failure. List only one cause on each line. MINAL PORTIC ANTI Immediate duse (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Doe to (of as a consequence of) the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic (Homoting 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown ans 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 TYes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ျှ Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 □ Yes 2 □No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner etated. Medical

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State

29b. Signature and title of certifie

(Check only one)

THE GOD DIST

Waysh Roca Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

			State of Marylar	•	rtment of Health and Natificate of Death		711115	1201.3
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate of Death	Reg. N	0000	3. Time of Death
П	Physicia	an				Month March 22,	2005 Year	
	/Medic	al			4b. City, Town, or Location of Death		c. County of Death	9:40 P M
	Examin	er	4a. Fecility Name (If not institution, give street and number) Bradford Oaks Nursing Home		Clinton		rince Geo	rge ! s
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthr	lace (State or Foreign
	Director		217-36-6688	Yrs.	Months Days Hours Min.	Mar. 15,1	922 Mary	land
	D]	Usuel Residence of Decedent					
	arylar show			ty, Town or Lo				0d. Inside City Limits 1 ☐ Yes 2 🕱 No
	8a-f	cto	<u> </u>	per Ma				
	vith th	Dire	10e. Street and Number 16901 Swanson Road		10f. Zip Code 20744		itizen of What Coul S.A.	ntry?
	s 23e	Funeral Director		6 12 1	Vas Decedent of Hispanic Origin? (S		14. Race - Americ	ean Indian
	ltem Item	ü	11. Marital Status 12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No		f Yes, specify Cuban, Mexican, Puerti	Rican, etc.)	Black, White,	
36	irs af	by F	3 Widowed 4 Divorced Year or Dates:		I ☐ Yes 2 No Specify:		Specify:whit	e
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show the Madical Examiner must be motified at	ted	15. Decedent's Education	16a. Deced	lent's Usual Occupation kind of work done during most of wor	16b.	Kind of Business/In	dustry
2	thin 7 e. an "n Med	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	life. L	OO NOT use retired)			
7	filed with Hygiene. hther thai	Con	3	f	armer		gricultur	e
nd	be filed hal Hygid od other event, II	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maide		
Z	should be and Mental I s marked o	To	Thomas Warren Loveless	464 88 95	Elsie G		Day	0.41
Maryland			19a. Informant's Name/Relationship (Type, Print) Jeffrey T. Loveless, nephew		ig Address (Street and Number or Ru 1 Swanson Rd., Up			
	of Health of Health item 27 i		20a Method of Disposition 20b. I	Place of Dispo	sition (Name of	Date 20c.	_ocation - City or To	own, State
Baltimore,	permit. Pages Department of I Importent: If its any injury or o'		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State		natory or other place) emetery 03/2	6/2005 Upp	er Marlbo	ro. MD
	artme orten injuri		21. Signature of Funeral Service Licensee		. Name and Address of Facility	3/2003 CPP	JI 1201 100	10, 110
Ba	permit. Departr Imports any inji		William Rary	Ra	usch Funeral Home	, P.A., Ow	ings, MD	20736
			23a. Part1. Enter the disease, or complications that caused the dear shock, or heart failure. List only one cause on each line.	th. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	· con	annal			Onset and Death
	/Medical		resulting in death) Due to (or as a consec	quence of):	77	12		
ı	Examiner		Sequentially list conditions, b.	can	y Cherry	0 000	ac -	
	Pe iis	Examiner	Sequentially instrumentation of any leading to immediate cause. Enter Underlying Cause (Disease or injury that stitled quarter	Juento JI).	1 Laton	of me		
	and and I-trans	xam	that initiated events resulting in death) Last C. Due to (pr as a consecution of the con	Tuence of):	no	- July	-	
8760,	icate be executed physician and s the burial-transit	aiE		Re	to,			
687	icate phys s the	edicai	d					
Box (eath certific attending p	J/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregn		1-		23d. Date of delive	ary
ă	atte	Physician/Me	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of control 2 Peters		Ectopic pregnancy Other (specify)		Month	Day Year
P.O.	that the de ed by the detached	hys	9 ☐ Unknown 9 ☐ Unknown					
	res tha igned be del	by P	Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to t	ne cause of death?
g	w require been sign	ted	The a Constitution	200	a James	_S 1 ☐ Yes	2□No 3□Prot	pably 4 Hunknown
Records,	lawri asbe	Completed	Hyportonsion	a	trial	24a. Was an autopsy	24b. Were auto	psy findings available impletion of cause of
<u>m</u>	sician: The law certificate has E irector, page 2 s	Con	2 Brillation			performed? 1 ☐ Yes 2 ☐	death?	
Vital	cian: ertific	Be	25. Was case referred to medical examiner?		100000000000000000000000000000000000000	th (Check only one)		
) t	Physician: r this certific ral director,	1º		ER/Outpatien		ome 5 Residence		(y)
n C	ling F	lon	27. Manner of Death 1	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
Sic	Attending r death. ector: After	icat	2 Accident investigation 3 Suicide 6 Could not be	ome farm str		28f. Location (Street	and Number or Rur	al Route Number.
Division of	of or Attendater death after death Director: /	Certification:	4 Homicide determined building, etc. (Speci	fy)	cot, lactory, office	City or Town, Sta		
	Hospitel or 24 hours after Funerel Directory filled in the proof of th		29a. Certifier 12 Certifying Physician: To the best of my kn					
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only one) Madical Examiner: On the basis of examiner and manner stated.	ation and/or in	vestigation, in my opinion, death occu	rred at the time, date a	nd place, and due to	o the cause(s)
	To t com	Σ	29b. Signature and title of certains	7	29c. License number	29d. D	ate signed (Month,	Day, Year)
)			Wroce Mil		100h	1 //	ar L	12009
	IV		30. Name and address of person who completed cause of death (Itel	m 23a) (Type,	Print) 9131 1-	scala	way	100
	10		31. Date filed (Month, Day, Year) 32. Registres Sign	ature		2/11/	10	121
	Sta Registi		MAR 2 4 2005 > Mayer	er K	Sparle			
					7 /			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 2005 3:30 a March 22 Mildred Ward Lyons /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sandy Spring If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Montgomery Brooke Grove Rehab and Nursing 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 X F Aug 6, Director 100 215-48-2586 Usual Residence of Decedent death with the Maryland 10a. State 10c, City, Town or Location 10d, Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ent of Health and Mentat Hygiene. ant: If item 27 is marked other than "natural; or items 23a or 28a-f show my no other than "natural" or them 27 is more and other than "natural" or other traumatic event, the Marical Exterior must be notified at my or other traumatic event, the Marical Exterior must be notified at 1 ☐ Yes 2 ☑ No Director Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 USA 3100 North Leisure World Blvd # 1026 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 27 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: ρ 3X Widowed 4 □ Divorced Year or Dates: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Norfolk Etta Robert Ward 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 Is any injury or other trac Joyce L. Terhes, daughter 3100 N. Leisure World Blvd., Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State All Saints Cemetery 03-25-2005 Sunderland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature d' Funeral Service Licensee 22. Name and Address of Facility 1.1.00 mm B. Paugeh Funoral Homo 20736 D A Owings MD

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

-	0000000	1. 04-6.12	Rausci.	r mierar nom	C, F.A.,	Jwings,	FID 20/30
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.					Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition		MYDERVERY	1 Inforc	11017		de
	resulting in death)	Due to (or as a conseq					
	Sequentially list conditions,	b. Due to (or as a conseq	Hence of)-				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	derice ory.				
	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):				
	(d					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 □Ectopic p			23d. Date of de Month	blivery Day Year
	Part II. Other significant conditions or	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco	\ .	to the cause of death? Probably 4 Unknown
					24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of s 2 No
	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)		
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 D	OA Other: A Nursing H	lome 5 Residence	6 ☐Other (Spe	ecify)
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 ∐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, lactor ý)	ry, office	28f. Location (Street City or Town, Sta		iural Route Number,
		ysician: To the best of my kno iner: On the basis of examina and manner stated.					
I	29b. Signature and title of certifier	_	29	c. License number	29d. E	ate signed (Mon	th, Day, Year)
	> /III ALL	P44510	167	D0055694	7	lorch.	22, 2005

20832

DHMH 17 Rev 1/2001

State Registrar

ALOK

within 24 hours a

4000

32. Registra Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATHUR

31. Date liled (Month, Day, Year)

MAR 2 4 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Day **Physician** 0400 AM Messick ornelius 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice at the Lake Salisbury Wicomico wastal If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 10 M 2□ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 Is marked other then "neturel", or Items 23a or 28e-f show treumatic event, the Medical Examiner must be notified at BIVALVE 1 ☐ Yes 2 ☑ X 0 Director WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21814 TICOKE HOAD AZU Funeral 12. Was Decedent Ever in U.S.
Amed Forces?
129 Yes 2 □ No WWIT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FUNERALHOME MORTICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill and Mental H Be ORNELIUS GLENN MESSICK SR TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is m any injury or other treum once. PO BOX GI BIVALVE, MD 21814 JEAN MESSICK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BIVALUE CEMETERY 3-26-05 BIVALVE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
MESSICK FUNERAL HOME PO BOX GI
BIVALVE, MD 21814

Approximate 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA, Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause puisaase or injury that initiated events Due to (or as a consequence of) Examine use as the burial-transit requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes 2 No 1 TYes or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 2 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes No 3 this ate of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deal 28b. Time of 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending death. 1 Tyes 2 No investigation within 24 hours after death To the Funerel Director: completely filled in by the t filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Much anne PO BOX 1733 address of person who completed cause of death (Item 23a) (Type, Print) JAMES W 1SAACS SALISIBURY

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Pay, Year) MAR 2 8 2005

32. Resstrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			FOI	State of Maryland	Department of H			2000	I arm as a
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of t		Reg. 2. Date of Death		3. Time of Death
	Physicia /Medic		JOHN M. MC	CORKLE			MARCH:	23, 2005	2:35P.M
	Examin	er	4a. Facility Name (If not institution, give st	reet and number) TATION EXTENDED		Cocation of Death	MORE	4c. County of Death	CRE
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Coui	place (State or Foreign
	Director		Usual Residence of Decedent	62	Yrs.		11/16/	42	PA
	show	70	10a. State 10b. County		own or Location				0d. Inside City Limits
	the M	Director	MD WICON	131	10f. Zip Code		10g.	Citizen of What Cou	
	238 or			SHELL LAN	- 1	14		USA	
	iter de la	Funerai	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 Dives 2 No 1960	13. Was Decedent of Hilf Yes, specify Cuba	ispanic Origin? (Spec in, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Americ Black, White,	etc.
15-0036	i within 72 hours after death with the Maryland liene. r then "natural", or Items 23a or 28a-f show the Medical Evaningt must be notified at	by	3 Widowed 4 Divorced	Year or Dates:	5	Specify:	1	Specify: W	
7	within 72 t ene. then "natu	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occup: (Give kind of work done of life, DO NOT use retired	durina most of workin	g	o. Kind of Business/In	
7				9	REALATOR	10. Mothode Nemo		REALES	TATE
/land	be de la	To Be	17. Father's Name (First, Middle, Last) SOHN GORDON	McCORKLE		18. Mother's Name	McLA	AUGHLLIN	
Mar	and 2 should ealth and Mer m 27 is marke ner traumatic		19a. Informant's Name/Relationship (Typ DR MICHAEL McCO)		19b. Mailing Address (Street a	and Number or Rural	Route Number, Ci	ty or Town, State, Zip	Code)
Baltimore,	es 1 al of Hea of Item of othe		20a. Method of Disposition 1 Darial 2 Foremation 3 Re	20b. Plac	e of Disposition (Name of etery, crematory or other place	Da	1	. Location - City or To	
<u>=</u>	Pa men ent: ury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 	SALI	SBURY CREMYS 22, Name and Address	TOTA 3/28	IOS DA	LISBURY.	,
r T	permit. Departi Import any inj		Criterin Reside	# M00416	MESSICK	FENERS	一片影片	PO BOX	91
			23a. Part1. Enter the distase, or complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused the death.	× 1	710 22 344 545		6	Approximate Interval Between Onset and Deam
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequen	ANCER WIT	H MEI	457A51	5	+ months
	Examiner	_	Sequentially list conditions, b.	Due to (or as a consequen	are off				
	outed id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	250 (0) (0) (0) (0)					
60,	death certificate be executed e attending physician and od for use as the burial-transit		resulting in death) Last	Due to (or as a consequen	nce of):				
09/89	ifficate I g physi as the t	edical	d.						
ROX	leath certifica attending pl ifor use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnancy	eath 3 Ectopic pregnancy			23d. Date of deliver	ary Day Year
o.	at the dea by the a stached fo	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of deat 9□Unknown	h 5 Cother (specify)				
S,	as tha	by PI	Part II. Other significant conditions cont	tributing to death but not resulting	ng in the underlying cause give	en in Part I.		co use contribute to t	
örd	w require been si should b	eted					1 Tes		pably 4 Munknown
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VIta	icien: certifica ector, p	Be	25. Was case referred to medical examiner?	ospital:	Oth	26. Place of Death	(Check only one)		
	≥ .∞ ठ	n; To	27. Manner of Death	1 Inpatient 2 EH	VOutpatient 3 DOA Bb. Time of 28c. Injury Vori	4 X Hursing Horr	ne 5 ☐ Residence 8d. Describe how i	e 6 Other (Special njury occurred	y)
Division of	ttendin death. stor: Aft / the fur	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		M 1 🗆	Yes 2 □ No	9f Location (Street	t and Number or Rura	A Courte Alumbas
<u>></u>	s after of all Direct of Indian	Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, onice	2	City or Town, S		n Addle Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my knowle er: On the basis of examination and manner stated.	edge, death occurred at the tin and/or investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the caused at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	Tour M	29c. Licens	e number	29d.	Date signed (Month,	Day, Year)
	X.		30. Name and address of person who, equ	moleted cause of death (Item 2)	3a) (Type Print)	14758	MA	12CH 23	2005
_	19		AURORA C. TAIN	3900 LOG	CH RAVEN	BOULEVA	FRD BAL	TIMORE,	M) 21218
	Sta	ate	31. Date filed (Month, Day, Year) MAR 2: 8 20	32. Figistrar's Signatur	V lank.		Ī		

			. For	-		Department of I	Health and M	-	•	10017
			State Registrar			Certificate of	Death		Reg. No.	12041
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	/Medic		Victor Jule Maid					March	23, 2005 Yeer	10:10P M
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)			or Location of Death		4c. County of Death	
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	Funeral Director		5. Social Security Number 6. Sex 1 ☑ 1 ☑ 1 ☑ 1 ☑ 1 ☑ 1 ☑ 1 ☑ 1 ☑ 1 ☑ 1	M 2□F	(In yrs. last bi	Yrs. Months Days		8. Date of Birth (Month, Da) Aug 18	y, Year) 9. Birthy Coul	place (State or Foreign ntry))
	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m and another				10d. Inside City Limits
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	be filed within 72 hours after death with the Maryland tal Hygiene. de ther than "natural", or Items 23e or 28e-f show of ther than "natural", or Items 20e or 28e-f show event, the Medical Examination at the notified at	Directo	Maryland Montgomer 10e. Street and Number	У	Silvei	Spring 10f. Zip Code			10g. Citizen of What Cou	ntry?
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	death rms 2	Funerai		12. Was Decedent E		13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sr			
9	or Ite	Ē	1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	0	1 ☐ Yes 2 ☒ No		rican, etc.)		etc.
9	ural',	d by	3 Widowed 4 Divorced	Year or Dates:					Specify: Whit	
Maryland 21215-0036	s filed within 72 F I Hygiene. other than "natuent, I'm Wedica	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a	 Decedent's Usual Occu (Give kind of work done life. DO NOT use retire 	pation during most of work	ring	16b. Kind of Business/In	dustry
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0	filed Hygi other ent,	BeC	17. Father's Name (First, Middle, Last)	-			18. Mother's Nam	e (First, Middle,	Maiden Surname)	
a	should be nd Mental marked o	To B	John Grover Maiden				Annie I	orena W	iles	
ary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Typ	ов, Print)	191	o. Mailing Address (Stree	t and Number or Ru	al Route Numbe	er, City or Town, State, Zip	Code)
_	alth 27 er tr		Hope A. Maiden/wif	e				-	ilver Spring	
00	ges 1 t of H If ite or otl		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemete	of Disposition (Name of ary, crematory or other pla	1	h 28,	20c. Location - City or To	own, State
Baltimore,	t. Pa rtmen rtant: njury		'4 □Donation 5 □ Other (Specify)		Gate o	of Heaven Ce			Silver Sprin	
Ba	permit. Pages 1 a Department of He Important: If item any injury or othe once.		21. Signature of Funeral Service License Severy L	to Utt	MO125	Beverly L.	Heckrott	e, P.A.	ce P.O. Box Clarksville	
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused to be cause on each line	the death. Do	not enter the mode of dy	ing, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
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ord	equir sen si sould		Severe Aortic Sten	osis; Atr	lal Fi	orillation		1 🗆 Y	′es 2 No 3 Prot	oably 4 🖾 Unknown
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o	Attending Phy ir death. ector: After thii by the funeral c	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury Wo	ork?]Yes 2 □ No			
Division of Vital Records,	I or Attenc after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur	ry - At home, f	arm, street, factory, office		28f. Location (S City or Tow	Street and Number or Rura n. State)	al Route Number,
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	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Examin	ician: To the best of er: On the basis of and manner stat	f my knowledg examination a ed.	e, death occurred at the t nd/or investigation, in my	ime, date and place, opinion, death occui	and due to the or red at the time, or	cause(s) and manner as s date and place, and due to	tated. o the cause(s)
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			VAMILIA /			- D	11218		3/24/0	25
1	200		30. Name and address of person who co							
2)			Charles Harrison M			er Mill Rd.	Rockvill	e, MD 2	0855	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 5 20	32. Rigistra		Sperte				

/Medi	ian		ame (First, Mide	07/26		K Ä H	lor				_	2. Date of De Month pr 1, 20		Year	3; Time of Death
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Exami	ner		Bible Hill			30.7		Oldto					Allega	any	
Funeral Director		5. Social Securit 236-66-	ty Number	6. Sex		. Age (In yrs. I	last birthday, Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir Dec 25	† 1926	9. Birth	nplace (State or Fore untry)
yland how		Usual Residence	10b, Count	•		10c. City	y, Town or L								10d. Inside City Lim
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 1:56 P M MARCH 18, 2005 JOHN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**M 2□F Months Director 215-72-2044 42 NOV. 1962 MARYLAND Usual Residence of Decedent should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or flems 23a or 28a-1 show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination at the notified at once. 1 Yes 2 □ No Director MONTGOMERY SILVER SPRING MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8811 COLESVILLE RD. 20910 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Yes, Give 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Year or Dates: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE UNK. NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 **GREENSON** UNKNOWN **EVELYN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREENBELT, MD. 20770 WILLIAM HUNT/FRIEND 7 OLIVEWOOD CT., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 3-24-2005 RIVERDALE, MD. 21. Signature of Funeral Service Lifensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 1/1 MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIPLE SCLEROSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 1 Yes 2X No To the Hospital or Attending Physician: 26. Place of Death (Check only one)

this filled in by the funeral : After

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Be 10

Certification:

Medical

State

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death 1 X Natural 2 Accident 3 Suicide

4 T Homicide 29a Certifier

29b. Signature and the of certif

5 Pending investigation 6 Could not be determined

Hospital: □ Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D24348 29d. Date signed (Month, Day, Year) 3.18.2005

pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who

fterman WEW 31. Date filed (Month, Day, Year)

2005

Registrar's Signature

1500 FOREST CLEN Rd, SILVER SPRING, MC 20910 MD

Director:

within 24 hours a

		_	For State Registrar	State of M	arylan		artmen rtificat			and M		Reg. No.	005	12	050
	Physici		1. Decedent's Name (First, Middle, Helen Watts M:	Last) Lchael							2. Date of Dea Month March	Day	2005	3. Time (of Death
	/Medic Examin	100	4a. Facility Name (If not institution,	give street and number)			4b. City,	Town, or	Location of	of Death	1102 011		ounty of Death	1.2	.0 1
	Exami	<u>. </u>	Doctor's Commun:	ity Hospital	L		Lanh	nam					nce Geo		
	Funeral			5. Sex 7. Ag		last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birthp Cour 12 Mary	lace (State try)	or Foreign
	Director		578-32-3385 Usual Residence of Decedent	1 2	92	Yrs.					Dec. 19	9, 19	12 Mary	land	
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside (City Limits
	Many e-f sh	ctor	Maryland Prince	George's	Gre	enbelt								1 <u>X</u> Y <i>e</i> .	s 2 No
	or 28	Oire	10e. Street and Number				10f. Zip						n of What Cour	itry?	
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396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other traumatic event, if a Medical Evain in trinsite rotified at ODGe.	by Funeral Director	11. Marital Status 1 □ Nøver Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 □ Yes 2 ▼ If Yes, Give Year or Dates:			Was Deced If Yes, sped 1 □ Yes	cify Cuba	Specify:	gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	etc.	
21215-0036	72 hou	Completed	15. Decedent' (Specify only highest	s Education		16a. Dece	dent's Usua	al Occupa	ation during mos	t of work	ina	16b. Kind	of Business/Inc	dustry	
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT u	se retired	1)		,,,,	11 0	0 -		
21	12 should be filed within and Mental Hygiene. 7 is marked other than "fraumatic event, the Men	Co	17. Father's Name (First, Middle, L			Execu	tive	Seci			e (First, Middle,		Govern	ment	
anc	otal F	Be c		asi/					Mary			Walder St	inane,		
Maryland	shoute nd Me mark matic	은	Raymon K. Watts 19a. Informant's Name/Relationsh	p (Type, Print)		19b. Mailir	ng Address				al Route Numbe	er, City or T	own, State, Zip	Code)	
	nd 2 salth ar 27 is r trau		Fran Elliott - I	aughter		3A G	arden	Way	, Gre	enb	elt, Ma	ry1an	d 20770		
ce,	s 1 a		20a. Method of Disposition	a Damend from Chate	20b. P	Place of Disponentery, crea	sition (Nar	ne of ther plac	e)		Date	20c. Loca	ition - City or To	wn, State	
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Baltimore,	permit. Departi Import. any inj		21. Signatura Farsal Service L	MOI	37				ss of Facilit		asch's : enue, H			-	
	Frysician /Medical Examiner		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. <u>Acute</u> Due to (or as	_{ne.} Iyoca	rdial				cardiac	or respiratory ar	rest,		Approxima Interval Be Onset and	etween
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.O. Box 68	the death certifi y the attending ched for use as	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3[∃Ectopic pi ∃ Other (sp		,			23	d. Date of delive Month	ery Day	Year
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Records,	The law ate has b page 2 si	Completed									24a. Was autor perfo 1 Yes	an osy rmed? 2 🕅 No	24b. Were auto prior to co death? 1 \(\sum \text{Yes}	mpletion of	s available cause of
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of\	Physic this c	은	1 ☐ Yes 2 X No	Hospital:		ER/Outpatier	_	-	4 🗀 140	ırsing Ho	ome 5 Resident			y)	
uc	ding h. After fune	lon	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investig		ly Year)	Injury	M	28c. Injun Worl	yaı k? Yes 2□	No	200. Describe i	iow injury t	occurred		
Division	Atten er deat ector: by the	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 290 Place of In			reet, factor				28f. Location (S City or Tox		Number or Rura	l Route Nu	mber,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edical C		Physician: To the best xaminer: On the basis of and manner st	of examina										(s)
	within 2 To the complet	Me	29b. Signature and title of certifier					c. License	e number			29d. Date	signed (Month,	Day, Year)	
	(10)		1 David	n. Gold	mai	M.L	S 1	0043	374			Marc!	h 24, 2	005	
	10	e	30. Name and address of person value of M. Goldman	the completed cause of the many many many many many many many many	death (Iter)0 Ha	n 23a) (Type, nover	Print)	ay,	Green	nbel	t, Mary	land	20770		
	Sta Regist		MAR 2 5 (2005)	32. Regist	rar's Sign	ature									

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 2005 7:50 a M March 22, Dorothy Elizabeth Morris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mitchellville Prince George's Villa Rosa Nursing Home | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year August 19, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 1920 Massachusetts 84 Director 137-12-9351 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: if item 27 is marked other then "natural", or items 23a or 28a-f show injury or other traumatic event, it e Maolical Esa intermast be notified at 1 Yes 2 No Mitchellville Maryland Prince George's **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 Lottsford Vista Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Be Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: if item 27 is marked other then "ni any injury or other traumatic event, the Media ODEs. Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Delia Elizabeth Ferguson Rome Shoals White 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10409 Cleary Lane, Mitchellville, Maryland 20721 Margaret Ann Boles - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial /2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 7, 2005 Rutland, Vermont Calvary Cemetery 21. Signature of Funeral Service Licensies 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Parth Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Years Atherosclerotic Cardiovascular Disease /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medicai use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy 1 ☐ Live birth Y*e*ar Month detached for in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has funeral director, page 2 autopsy performed certificate 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 🖔 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 28b. Time of 5 Pending Injury 1 XNatural 1 Yes 2 No investigation 2 Accident after death the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 1X Certifying Physicier 2 Medical Exeminer: 29a. Certifier (Check only one) and anner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified D32261 March 23, 2005 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9500 Annapolis Road #A-4, Lanham, Maryland 20706-2061 Richard Fledman, M.D. 32. Registrar's Signature 2005 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1		artment of Health and Mer rtificate of Death	ntal Hygiene Reg. No	Z H H 5 1 7 H 5 7
			Decedent's Name (First, Middle, Last)		Date of Death Month Da	3. Time of Death
	Physicia /Medic	al	Margaret Ellen Miller	l N	March 18	2005 2135 PM
	Examin	_	la. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
			SunBridge Care Center Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Elkton If Under 1 Year If Under 24 Hrs. 8.	Date of Birth	9. Birthplace (State or Foreign
	Funeral		5. Social Security Number $\begin{array}{c c} 6. \text{ Sex} & 7. \text{ Age (In yrs. last birthday)} \\ 222-03-4755 & 1 \square \text{ M} & 2 \boxed{X}^{\text{F}} & 91 \end{array}$	Months Days Hours Min.	(Month, Day, Year UG 10, 19) 13 Delaware
	Director	-	Usual Residence of Decedent			
	yland yland		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	a-f sl	cto	Maryland Cecil Elkton			
	or 28	Dire	10e. Street and Number	10f. Zip Code		itizen of What Country?
	ath w	rai	1 Price Drive 11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify		ited States 14. Race - American Indian,
	er de Items	Funeral Director	11. Marital Status 1 Never Married 2 Married 1 1 9 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric	an, etc.)	Black, White, etc.
36	urs aft	by	If Yes, Give X 3 Wildowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 🛱 No Specify:		Specify: White
Maryland 21215-0036	d within 72 hours after death with the Maryland Jiene. Ir then "natural", or Items 23e or 28e-f show Itte Medical Examinar must be twillfied at	ted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b. I	Kind of Business/Industry
215	within 7 lene. than 'n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired))
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and T	ld be filed ental Hyg ked othe ic event,	Be	Joseph Kemether	Reba E.		·· • -··,
交	should be tand Mental I s marked o	ဥ		ng Address (Street and Number or Rural R		or Town, State, Zip Code)
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as .	s 1 and 2 shou if Health and M item 27 is mar other traumat		20a. Method of Disposition 20b. Place of Disposition		20c. l	Location - City or Town, State esapeake City,
Ë	Page ent o nt: # ry or		1 Xi Rurial 2 Cramation 3 Hemoval from State	Cemetery 2005		yland
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot		21. Sign ture of Funeral Service Licensee	2. Name and Address of Facility icks Home for Funer: 03 W. Stockton Stre	als. P.A.	
<u> </u>	89 = 89		Donud & Hicker 1	03 W. Stockton Stre	et, Elkto	on, Maryland 21921 Approximate
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	Physician		Immediate Cause (Final disease or condition resulting in death)	Hear Viseases		ymnown
	/Medical Examiner		Due to (or as a consequence of):			
	2	ا <u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury			
	uted d ansit	Examine	cause, Enter Underlying Cause (Disease or injury that initiated events c			
o,	an an rrial-tr	Exa	resulting in death) Last Due to (or as a consequence of):			
8760,	The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	d			
9	ertifica ling pl e as t	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	eath certific attending pl	ian/	in the past 12 menths?	□Ectopic pregnancy □ Other (specify)		Month Day Year
P.O.	the de	ysic	1 Yes 2 Mo 9 Unknown			
	that the de ned by the a detached f	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds	w requires that s been signed to should be deta	d by			1 Tes	2 ☑No 3 ☐ Probably 4 ☐Unknown
of Vital Records,	s bee	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
R	The k	E O			performed? 1 ☐ Yes 2 ☑	death? _
ita	ian: ortifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Plac of Death	Check onlone	
<u>></u>	hysic his ce Il dire	ဥ	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		5 Residence d. Describe how in	6 ☐Other (Specify)
n O	ing P	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at 28 Work? M 1 □ Yes 2 □ No	u. Describe non in	ury occurred
isio	ttend death stor: ,	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm, s		f. Location (Street	and Number or Rural Route Number,
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	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical Certification:	29a. Certifier (Check only [Oneck only 2] Madical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, an	d due to the cause	(s) and manner as stated.
	he Ho n 24 I he Fu pletely	edic	one) and manner stated.			
	To t To t	Σ	29b. Signature and title of certifier	29c. License number	29 0 . L	Date signed (Month, Day, Year) 3.23,05
)			Jachdy S MD	J0000)		Jixor
S)			Doo 23322 Suit 3B, Eleton	, MD2	1921.
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	W		

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Sequentially list conditions, if any, leading to immediate Cause. Birst underlying Cause. Birst underl	Approximate Interval Between Onset and Death
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The state of the s	livery Day Year
25. Was case referred to medical examiner? 1	
25. Was case referred to medical examiner? 1	robably 4 Unknown utopsy findings available
27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at 28d. Describe how injury occurred work?	completion of cause of
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To be the second of the second	city)
2 Accident 2 Accident 3 Suicide 4 Homicide 4	ural Route Number,
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as so Section 1 Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as so Section 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as so Section 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as so Section 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion.	s stated. e to the cause(s)
to give to be placed to be plac	
D23371 APRIL 2	2,2005.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Or. 2. 2. 2. 2. 2. 3. Date filed (Michith, Day, Year) 32. Registrar's Signature	

Registrar



			For State		5	State of I	Marylaı		artmen			and Me			Ph 7-0	1 /3 /2 (200)
			Registrar 1. Decedent's Name	e (First, Middle,	Last)				Timeat	011	Jeani	2	2. Date of Dea		UD-	3. Time of Death
	Physici /Medic		James		Н.		M	litchell					Month	Day Q3	OS	10:410 A.M.
	Examir		4a. Facility Name (/	f not institution,	give str	eet and numb	er)		4b. City,	Town, or	Location	of Death	1	4c. Coun	ity of Death	1
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	Funeral Director		5. Social Security N 215-20-6		6. Sex 1 ⋉ N	7. 1 2 F	Age (In yrs.	. last birthday, Yrs.	Months Months	Days	If Under Hours	Min.	S. Date of Birth (Month, Day Sep 13	Year)	9. Birth	pplace (State or Foreign intry)
			Usual Residence of				10						оер го	, 1920		
	nylan how		10a. State	10b. County Alleg	anv		10c. C	ity, Town or Li LaVa								10d. Inside City Limits
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(O	or items	표	1 Never Marri	ied 2 Marrie		Armed Force	∋s? □ No					, Puerto R	ify Yes or No- ican, etc.)	1	lack, White	, etc.
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	filed Hygid other		17. Father's Name	· -	ast)			Conde	ictor		18. Mothe	r's Name (First, Middle,			<u>u</u>
<u>lan</u>	2 should be filed within 72 hours aft and Mental Hygiene. Is marked other the "natural", or sumatic event, the Medical Exama	To Be	Raymo	ond Mitc	hell						Lura	a Mit	tchell			
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-	s 1 and of Health item 27 other tr		Kay Mitc									ue Da	-	20c. Location		
סר	Pages nent of H int: If ite		1 XBurial 2	Cremation		noval from Sta		Place of Disponence of Chicago Control of Chicago Chic					6/2005			MD
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Re	The fa ate has page 2	dwo											autop perfor	sy med? 2 X No	prior to death?	ompletion of cause of 22 No
ita	an: Trificat	0	25. Was case refer	red to medical							26. Place	of Death (1 ☐ Yes Check only o		1 185	2,40,110
Ž	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🔀	No	Hos	spital: 1 🗆 Inp	atient 2	ER/Outpatie	nt 3 DC	Othe	өг. 4 □ Nu	rsing Home	e 5 🗆 Resid	ence 6 🗆 O	ther (Spec	ify)
0 [ing PI	00:	27. Manner of Deat	h 5 🗆 Pending		28a. Date of I (Month,	Injury Day Year)	28b. Time of Injury		8c. Injury Work			ld. Describe h	ow injury occi	urred	
Sio	death. ctor: A y the fu	catl	2 Accident 3 Suicide	investig 6 ☐ Could n		On - Disease	Imiron At 6	ama farm at	M		Yes 2		of Location (C	trant and Alug	mbos os Ow	en l Courte Number
Division	after of Direct of In Direct of	Certification;	4 Homicide	determi		28e. Place of building.	, etc. (Spec	ify)	reet, tactor	, office		20	City or Tow	n, State)	nder or Hui	ral Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier	1 Certifying	Physic	ian: To the be	est of my kn	owledge, dea	th occurred	at the tin	ne, date an	d place, an	id due to the o	ause(s) and r	nanner as	stated.
	ne Ho n 24 h ne Fu	Medical	(Check only one)	2 Medical E	xamine	r: On the basi and manner	s of examin	ation and/or ir	nvestigation	, in my o	pinion, dea	th occurred	at the time, o	late and place	e, and due	to the cause(s)
	To the within 2 To the comple	ž	29b. Signature and	title of certifier							number			29d. Date sign		
•			tav	IJ.	no	erpoor	KMD)		73	774		/	APRIL	3,6	2005
			30. Name and addr							_	Cum	1-0	1.4.12	A	7	^ >
	- 01		31. Date filed (Mon	LIVEN	000		distrar's Sign	SETON	DIZIV	=	Lum	DEK.	LAND	my	2156	72
	Sta Registi		AFI		05		1	A SON	160							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend items 4a b 26 per doc 842 4-6-05 yt
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year MILLER 9,58 60068 VIIUATA 2005 /Medical 4a. Facility Name (If not institution, give street and number)
4244 Horine Road 4b. City, Town, or Location of Death **Jefferson Examiner** 4c. County of Death Hospital Frederick If Under 1 Year If Under 24 Hrs. Months Days Hours Min. May 28, 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 89 160-16-9583 Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD Frederick Jefferson 1 ☐ Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4244 Horine Road 21755 or Items 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ White Specify-3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fill Health and Mental H tam 27 Is marked ott George Myers Miller Evna V. Calp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Bertha E. Miller/Wife 4244 Horine Rd., Jefferson, MD 21755 othar 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages . 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State March 29, ō Department of Middletown Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Freeland, MD 2005 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Signature of Smeral Sprvice Light 24 Second St., New Freedom, PA 17349 ty. Ente the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, earl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** CONGESTIVE HEART FAILUNG WEELE S /Medical resulting in death) Due to (or as a consequence of) **Examiner** MYOCAMDIAL INFANCTION WEEY, ALUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and sthe burial-transit Due to (or as a consequence of) Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ cholt (45TITI) 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death Check only one) examiner' Other 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 € No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred or Attanding 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral 6 Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3/28/2005 D-31912 TAD

Registrar

State

JULID

SOLIE am DINE LEWELL MD 51105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEMOCIA MD

0 7 2005

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			1 - For State Registrar	State of Marylan	d / Depa	artme	nt of H	lealth and Death	Mental Hy		2005	12050	7
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	Physici /Medio			Nuble					March	1 23	2005	3:76A	M —
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	Funeral		5. Social Security Number 6. Sex		last birthday)		er 1 Year	If Under 24 Hrs	8. Date of Bir			thplace (State or Forei	gn
	Director		217-18-1981 1 Usual Residence of Decedent	M 2	6 Yrs.	Month	Days	Hours Min.	8. Date of Bir (Month, Da Aug 24	, 19	18 V	irginia	_
	r 28e-f show	tor	10a. State 10b. County Maryland Cec:		y, Town or Lo		sapea	ke City				10d. Inside City Limi 1 ☐ Yes 2 🔀 N	
	with the	i Director	10e. Street and Number 266 Cayots Con	rner Road		10f. 2	ip Code 219	15		10g. Cit	izen of What C	ountry?	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Dec	edent of H	ispanic Origin? (S	Specify Yes or No to Rican, etc.)	>	14. Race - Am		
920	within 72 hours after death with the Maryland ene. than "netural", or itams 23a or 28e-f show the Medical Examinar must be multived at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🌠 Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1		ecity Cuba 2₩ No	Specify:	to rican, etc.)		Black, Whi	_{te, etc.} Black	
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Ma	12 ha 7 is		Cynthia H. Casteel		1	_			Linton, 1				
ore,	T to		20a. Method of Disposition	20b. F	lace of Dispo emetery, crei				Date		ocation - City or		-
Ë	nit. Pages partment of h ortent: If it injury or o'		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re ' 4 ☐ Donation 5 ☐ Other (Specify)	enioval noin State	ohemia			1 .	8/05	Che	esapeake	e City, MD	
Baltimore,	permit. Page Department of importent: if any injury or ance.		21. Signature of Funeral Service License		22	2. Name Lis	and Addres	ss of Facility ott Funer	cal Home	, P.	Α.		
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Вох	The law requires that the death certificate be execuled tite has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 SNo 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3[⊒Ectopic ⊒ Other (pregnancy specify)				23d. Date of de Month	livery Day Year	
, P.O.	es that tigned by	by Ph	Part fl. Dther significant conditions com	stributing to death but not res	ulting in the u	ınderlying	cause give	en in Part I.	23e. Did t	obacco (use contribute to	the cause of death?	
ords	w require been sig should b	ted t	HYPERLIPIDEMIA						10	Yes 2	No 3□P	robabfy 4 Unknow	m
Records,	The law rate has be page 2 sh	ompieted	Ischemic C	CHEDIOTHYOPATH	1				24a. Was autor perfo 1 \(\text{Yes}	osy ormed?	prior to death?	utopsy findings availab completion of cause of 2 No	le
Vital		Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only o			22310	
of V	Physicien: this certific ai director,	To	1 ☐ Yes 2 🕱 No		ER/Outpatier		Oth	er: 4 Nursing H	dome 5 Resid			icify)	
ion	D 9 9	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of M	28c. Injun Worl	vat ⟨? Yes 2 □ No	28d. Describe	how injui	y occurred		
Division	el or Attendin s after death. si Director: Af ed in by the fur	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str v)	reet, facto	ry, office		28f. Location (S City or Tox	Street an wn, State	d Number or R	ural Route Number,	
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurre ivestigation	d at the tim	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as f place, and due	s stated. e to the cause(s)	
	To th within To th compl	Me	29b. Signature and title of certifier			2	9c. License		1		te signed (Mont		
)			> Louder	m.D.			_D 0	05839	2	MARC	n 23,	2005	
	2		30. Name and address of person who could be say that the same says the same says that the same says that the same says the same says the same says that the same says		123a) (Type,		(, &	LKTON,	MD 2192	-)			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture								

		For State Registrar		of Maryland / D	epartment of I Certificate of			Reg. No.	05 1205
Physicia /Medic Examin	al -	Decedent's Name (First, Mid Ina 4a. Facility Name (If not institut	Theresa	Nethki		or Location of Dea	2. Date of De Month Mar 30,	2005	Year 3.1 Time of Debuth 10:50 arm
Funeral		Allegany Coun 5. Social Security Number	ty Nursing I	7. Age (In yrs. last birth	Months Davs	If Under 24 Hr		Allegar, Year)	Birthplace (State or Foreign Country)
Director		213-12-9394 Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City, Town	or Location		Jan 10), 1920	MD 10d. Inside City Limits
vith the Mar or 28a-fat Le notified	Funeral Director	10e. Street and Number	ieral	For	t Ashby	00740		10g. Citizen of	·
033 Ir., o	۵	P.O. Box 484 11. Marital Status 1 Never Married 2 M 3 Widowed 4 Divorce	arried 1 ☐ Yes	Ve No Vates:	13. Was Decedent of If Yes, specify Cut 1 Yes 2 No	Specify:	(Specify Yes or Narto Rican, etc.)	o- 14. Ra Bla Specii	SA ce - American Indian, ick, White, etc. fy: white Business/Industry
-	e Completed	(Specify only high Elementary/Secondary (0-12 12 17. Father's Name (First, Middle)	hest grade completed) College (1-4or 5+)	Give kind of work done life. DO NOT use retire Dept.	during most of w	orking ame (First, Middle	Tire Cor	mpany
and and seum.	ToB	F. Elmer Lep 19a. Informant's Name/Relatio Robert Suesse	nship (Type, Print)		Mailing Address (Stree	t and Number or I			
Baltimore, IN permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr		20a. Method of Disposition 1 🕅 Burial 2 □ Crematio 14 □ Donation 5 □ Other	n 3 Removal from	20b. Place of I cemetery	Disposition (Name of crematory or other plant of Memorial Park	ice)	Date 4/2/2005		- City or Town, State
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© ≅ G 3	W -	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live I	tcome of pregnancy birth 2 ☐ Fetal death nant at time of death lown	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	y		1	ate of delivery onth Day Year
Il Records, P. The law requires that I are has been signed by page 2 should be deta	Completed by Physician/M	Part II. Other significant cond Chrom Dolydrafic	assivat	leath but not resulting in	the underlying cause gi	ven in Part I.	1 🗆 24a. Was	Yes 2 □ No	tribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of Vita hysiclen his certifi I director	Certification: To Be (3 ☐ Suicide 6 ☐ Cou	Hospital: 1 28a. Date (Monstigation Id not be 28e. Place	of Injury 28b. Ti	me of 28c. Injury Wo	her: 4 🗷 Nursing	28f. Location	idence 6 ∐Otl how injury occur	
Hospitel c 24 hours af Funeral D etely filled ir	edical Cer	29a. Certifier (Check only one)	el Examiner: On the b	e best of my knowledge, pasis of examination and oner stated.	death occurred at the to	ime, date and pla opinion, death oc	ce, and due to the	cause(s) and m date and place,	anner as stated. and due to the cause(s)
Mithin To the complete	Me	29b. Signature and title of certification of the ce	tier That pywho completed caus	se of death (Item 23a) (T	ype, Print)	9 7 5 C)	Marce	d (Month, Day, Year)
Star Registra	ar	31. DAG ARANIITHA	7 2005	Registrar's Signature	nace Street	Ext. Cur	nberland	MD 215	02

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Month Physician 22, 3:00 March 2005 Owens Α Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Prince Georges 9400 Buena Vista Road Lanham If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 ☐ M 21X F 82 Yrs. 260-20-2751 May 15, 1922 Georgia Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show Examiner must be notified at 1√2 Yes 2 No Director Lanham Prince Georges permit. Pages 1 and 2 should be filled within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nation" any injury or other traumatic. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20706 9400 Buena Vista Road U.S.A. Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐Yes 2 No Yes, Give 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2 No Specify: Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Papadeas Andrew Skeliche ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3558 Second Avenue Edgewater MD 21037 George Andrew Owens- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 3/24/2005 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitFort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Road Brentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebral Thrombosis Years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐ Unknown Arteriosclerotic Heart Disease Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2K No page 2 s 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death | Director: / d in by the f 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide n 24 hours aft na Funaral D letely filled in 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DEC05891 3-22-65 Rogn B. Lingkom 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6510 Kenilworth Avenue Suite # 2400 Riverdale MD Roger Ingram MD. 32. Registrar's Signature 31. Date filed (Month, Day, State MAR 2 4 2005 Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Registrar

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State

31. Date filed (Month, Day, Year)

astrar's Signature

2005

111 Penn Street

Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene? 1 15 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day 25 **Physician** 03 14,40M 1/00/210 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WICOMICO Hospice athe DUVU 115 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Days Min. Months Hours 1 ☐ M 2 🖾 F Yrs. March 9, 1944 221-28-9848 Director Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ?7 is marked other then "neturel", or items 23e or 28e-f show treumatic event, the Mudical Exercities must be notified at 1 Yes 2 No Director MD Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 907 West Schumaker Manor Drive U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter to Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel" or iten any injury or other treumatic event, the Medical Exercipant once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 至 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Department Store 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Lynch Alvin E. Parsons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Snow Hill, MD 21863 (Cousin) 319 E. Market St. Cheryl Mullins 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 □ Donation 5 □ Other (Specify) Stephens Cemetery 3-30-2005 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home Delmar, DE 19940 a ewe E. Grove Street Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prysician DLIY /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a cons quence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit law requires that the death certificate be executed Due to (or as a consequence of) attending physician P.O. Box 68760 Physiclan/Medical the IF FEMALE: esn esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12-months? 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 3 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 2 npatient 2 ER/Outpatient 3 DOA 2 this ate of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Avatural after death. 1 Tyes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funerel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4256 05 rscock HUSPICE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UCDIsaacs SALISBUK 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State MAR 2 8 2005 Registrar

·			For State Registrar		of Marylar		artmen rtificat			and M		Reg. No	20	05	***************************************	2062
Phy	ysicia	ın	Decedent's Name (First, Middle								2. Date of De Month	Da		Year	3. Time 2:20	of Death ***
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Ex	amin	er,	4a. Facility Name (If not institution		iumber)				Location of				. County o			
			Bayside Care 5. Social Security Number	Center 6. Sex	7. Age (In yrs.	last birthday)		ingt 1 Year	on Pa		8. Date of Bir		Saint			e or Foreign
Fun Dire			577-46-9330	1 ☐ M 2 ∏ F	, , , , , , , , , , , , , , , , , , ,	92 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da September				itry) iryland	e o <i>r Foreign</i>
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nylan how	ā		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits			
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ਜੋ 9.28	2	Director	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of W	hat Cour	itry?	
. I Z I 3-UUSO within 72 hours efter death with the Maryland ene. than "natural", or Iteme 23a or 28a-f show	199	La l	Nottley Woods Lane					20621					USA			
er de	BELL	Funeral	11. Marital Status	Armed	cedent Ever in U Forces?	J.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Ori n, Mexican	gin? (Spi i, Puerto	ecify Yes or No Rican, etc.))-		- Americ , White,	an Indian, etc.	
s effect.	100	by F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Yes. 0	s 2∭No Give		1 ☐ Yes	2🛛 No	Specify:				Specify:	B1a	ack	
5-0036 72 hours ef natural', or	E .		Λ	it's Education	Dates.	16a. Dece	dent's Usua	al Occupa	ation			16b K	(ind of Bus	siness/Inc	dustry	
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Jid be Menta	tlc e	ToB	Sonny Herbert Julia Forrest													
iaryia 2 should and Mer is marke	emn.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												1	
and 2	er tre		James Herbert, Jr. / Grandson P.O. Box 351, Chaptico, Maryland 20621													
INTIMORE, IMARYIANG ZIZIO-UUSO III. Pages 1 and 2 should be filled within 72 hours efter death with the Marylan ariment of Health and Mental Hygiene. Greent: If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show	r of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □ Bemoval from	m State	Place of Dispo cemetery, crei	matory or o	ne of ther plac	θ)	Marc	Date h	20c. L	ocation - 0	City or To	wn, State	
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Dail permit. Departr Import	any inj	ſ	21. Signature of Funeral Service	Livensey)	1 -	22 Ma	2. Name an	d Addres	s of Facilit	y Fune	eral Home	P.,	4 .			
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			23a. Pary . Enter the disease, or shock, or heart failure. List	complications that only one cause or	t caused the dea n each line.	th. Do not ent	ter the mod	e of dying	g, such as	cardiac	or respiratory a	rrest,			Approxim Interval B	Between
Physic		1	Immediate Cause (Final disease or condition	a .	R Egg	sisato	21	au	lev	25	_				On et an	o Deam
/Med Exami	_		resulting in death)	Due t	o (oras a consid	q ence of):	1	0	01	11	4	Z			1.	
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death death	d for	Clai	in the past 12 months? 1 ☐ Yes 2 🖺 No	4□Pre	e birth 2 □ Feta gnant at time of c		∃Ectopic pr ∃ Other (sp						Mon	th	Day	Year
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Of VICA Physician:	director,	OB	examiner? 1 ☐ Yes 2 ∰ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DC	OA Cthe	er: 4 4 Nu	irsing Ho	me 5 Res	dence	6 Othe	r (Specify	4)	
on or ding Phys P. After this	neral	T:u	27. Manner of Death	28a. Dat	te of Injury onth, Day Year)	28b. Time o	f 2	8c. Injury Work	at		28d. Describe	how inju	ry occurre	d		
ath.	in fur	atlo		igation		,,	М		Yes 2	No						
IVISION r Attending ter death. Irector: Atte	by ti	ertification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	oined 289. Pla	ce of Injury - At h Iding, etc. (Speci	nome, farm, sti	reet, factory	, office			28f. Location (City or To			r or Rura	l Route Nu	umber,
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UIVISION OF To the Hospital or Attending Physwithin 24 hours after death. To the Funerel Director: After this	ely fil	edical		ng Physician: To t Examiner: On the												∋(s)
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2	7		30. Name and address of person	- 1/						_	0000					
	Cto		James P. Jarboe, 31. Date filed (Month Day, Year,	22	35 Three N Registar's Sign		id, Hol	. Lywoc	od, Mar	yland	1 20636					
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			1. Decedent's Name (First, Middle	, Last)					2	. Date of Deat			3. Time of Death		
	Physicia		HILDA	V.	PARK	ER				Month March	20,20	Year	11:00A ^M		
	/Medic Examin		4a. Facility Name (If not institution				4b. City, T	own, or Location of			4c. County				
	LXumm	٠.	Laurel Regi	onal Ho	spita	1	La	urel			Princ	rince George's			
	Funeral		5. Social Security Number	6. Sex		yrs. last birthda	y) If Under 1	Year If Under 24	4 Hrs. 8	. Dale of Birth					
	Director		218-12-0474	1 □ M 2 🔀 F	80	Yrs.	Months	Days Hours	Min.	Sept.	3,1924	Ma	place (State or Foreign intry) ryland		
			Usual Residence of Decedent												
	nylan how		10a. State 10b. County		100	c. City, Town or	Location						10d. Inside City Limits		
	Ma Me-1 s	to	MD How	ard		Lau	ırel						1 ∑X Yes 2 ☐ No		
	ith the	lre	10e. Street and Number				10f. Zip (Code		10	0g. Citizen of	of What Country?			
	th wi	al	9900 Harmo	ny Lane				20703			U.	S.A	•		
	ems ems	Funeral Director	11. Marital Status		ecedent Ever Forces?	in U.S. 13	3. Was Decede	ent of Hispanic Origi fy Cuban, Mexican,	in? (Specif	fy Yes or No-			ican Indian,		
٥	or It	F.	1 Mever Married 2 Marr		1 ☐ Yes 2					Black, White, etc. Specify: Black					
3	be filed within 72 hours after death with the Maryland Hydiene. die Hydiene. die other than "neturel", or Items 23e or 28e-f show dente, the Madical Examitier must be multied an event, the Madical Examitier must be multied an	d b	3 Widowed 4 Divorced Year or Dates:										JIGON		
215-0036	72 h	Completed	15. Deceden (Specify only highes	t's Education st grade complete	d)	16a. De (Gi	pedent's Usual ve kind of work	l Occupation k done during most (e retired)	of working		16b. Kind of B	usiness/l	ndustry		
2	vithin ne. han	mpl	Elementary/Secondary (0-12)	College	(1-4or 5+)	life					TT				
N	led v lygie her t		10 th 17. Father's Name (First, Middle,	/ noth			Domes		'a Nama //	First, Middle, M	Home				
ב	be find he do of ot	Be	Ollie L. M						,	Walla		(1 0)			
ž	12 should be filed v n and Mental Hygie I Is marked other t raumatic event, III	ို			•	105.11	W Add					01-1-7	5 0 1 1 1		
Maryland	12 st h and 7 Is n traun		19a. Informant's Name/Relations			11224039	7520	(Street and Number							
a)	1 and Health		Joan L. Clar	k - Sis		0b. Place of Dis	18 Ode		Bel Dat			D 20705 n - City or Town, State			
<u>0</u>	Se = 50		1 ☑ Burial 2 ☐ Cremation		m State	cemetery, c	rematory or oth	her place)				•			
	*4 Donation 5 Other (Specify) Mt. Zion Cem 3/25/20 2 Signal February Service Livenses 22. Name and Address of Facility Snow										Laure				
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury opother traumatic evence.		21 Signalum 1 Funeral Service	nse	with	en							,MD20850		
			23a. Part1. Enter the disease, or	complications tha	t caused the	death. Do not e	enter the mode	of dying, such as ca	ardiac or r	espiratory arre	est,		Approximate Interval Between		
3	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause or		UMONIA	1						Onset and Death 1 Week		
1	/Medical		disease or condition resulting in death)												
	Examiner				()	,									
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due t	to (or as a co	nsequence of):							,=		
	d d ansit	Examiner	Cause (Disease or injury that initiated events												
o	be executed ician and burial-transit		resulting in death) Last	Due	to (or as a co	nsequence of):			-						
760,	ate be executed hysician and the burial-transit	cal		d											
9	death certificate e attending phys d for use as the	Ned	15.55111.5												
X Q Q	th cer endir r use	an/A	IF FEMALE: 23b. Was decedent pregnant		outcome of pre-		3 □Ectopic pre	egnancy			23d. Da	,			
		slcle	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time		Other (spe				Mo	onth	Day Year		
J.	at the	Physician/Med	9 🗆 Unknown	Harris Ha											
	law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant condition Carcinoma			of resulting in the	underlying ca	iuse given in Part I.					the cause of death?		
ecords,	equir en si ould							·		1 L289 e	s 2 No	2 No 3 Probably 4 Unknown			
ပ္ထ	law r as be 2 sh	Completed	Carcinoma	of Par	otid	Gland				24a. Was ar	n 24b.	Were aut	opsy findings available ompletion of cause of		
r	The law cate has I page 2 s)om									ned?	death? 1 🗆 Yes	2 X No		
Vital	ysicien: Th is certificate director, pag	Be (25. Was case referred to medical examiner?					26. Place of	of Death (Check only on					
010	Physicien: r this certific ral director,	ပ္	1 ☐ Yes 2 No	Hospital: 1 [∑ Inpatient	2 ER/Outpat	ient 3 DO	A Other: 4□ Nurs	sing Home	5 🗆 Reside	nce 6 Oth	er (Spec	ify)		
0	ding Phys h. After this funeral dis		27. Manner of Death 1 XNatural 5 ☐ Pendin	28a. Dai (M	le of Injury onth, Day Ye	ar) 28b. Time	of 28	Bc. Injury at Work?		d. Describe ho					
0	tendii Jeath. tor: A the fu	atle	2 Accident investig	gation			М	1 Yes 2 N	lo						
determined 288. Place of injury - At nome, farm, street, factory, office									28	f. Location (Str City or Town	reet and Numb , State)	er or Ru	ral Route Number,		
2	itel or irs afte rel Dir led in	Cel	<u> </u>						ı						
	To the Hospitel or within 24 hours at To the Funerel D completely filled in	edical	29a. Certifier 1 Z Certifyir (Check only one)	Examiner: On the	the best of my basis of exa anner stated.	y knowledge, de mination and/or	ath occurred a investigation,	t the time, date and in my opinion, death	l place, and n occurred	d due to the ca at the time, da	use(s) and ma ate and place,	anner as and due	stated. to the cause(s)		
	To th within rompl	Me	29b. Signature and tille of certifie				29c.	License number		25	d. Date signe	d (Month	Day, Year)		
,			DH15	5000	enp 1	an		D 23	181		3-7	20-	2005		
	5		30. Name and address of person	who completed ca	use of death	(Item 23a) (Tvo	e, Print)		·····				_		
			R.G. Bmojr	aj, MD	704 G	orman	Ave #		rel,	MD 20	707				
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2	4 2005	Box.	Signature	April	,							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 20 Pay 2005 Prout Pau1 **Physician** 1520 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 39 9. Birthplace (State or Foreign Country) D.C. 5. Social Security Number 6. Sex **Funeral** 10√M 2□F 578-54-6567 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral', or Items 23a or 28e-f shov Examirer must be notified at 1 ☐ Yes 2 ☑ No Huntingtown Directo Marvland Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20639 3925 Capital Hill Lane Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or lien any injury or other traumatic event, I'le Medical Examiliations. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virginia Prout, Enoch 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Huntingtown, MD2063 3925 Capital Hill Lane Mattie Prout/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Patuxent UMC Cem. 3/25/2005 Huntingtown, MD 1 4 □Donation 5 □ Other (Specify) Funeral Home Prince Fred.,MD2067 Sew 21. Signature of Funeral Service Licenses Gladen a. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS SYNDROME **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Month Day Year in the past 12 months? ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ RENAI 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPER TENSION 24a. Was an autopsy performed CORONARY ARTERY 1 ☐ Yes 2 ☐ No 1 Yes 20 No funeral director, 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1_2Natural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 | Homicide within 24 hours after To the Funerel Dire To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D40370 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Wisniewski, M.D. Prince Frederick, MD 20678 32. Registres Signature 31. Date filed (Month, Day, Year) State MAR 2 3 2005 > Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Medical contes Baltin V855174 () If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Director 579-54-1106 1937 North Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show rthen "natural", or Itame 23s or 28s-1 shov the Medical Examiner must be notified at 1X Yes 2 □ No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #B-608 20032 4660 Martin Luther King Ave., S.W. United States filed within 72 hours after death 1 Hygiene. Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th Environmental Health Services Is marked other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If item 27 is marked oth any jury or other treumatic event pice. 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie Edward Purcell Izetta Galbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #B-608 Darius Goodman, Jr./Grandson 4660 Martin Luther King Ave., S.W. Wash., DC 20032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Harmony Memorial Park 3/26/2005 Landover, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service License® 4001 Benning Rd., N.E. Wash., DC 20019 was my 23a. Part1. Inter the disease, or complications that caus in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, riveart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C se (Final disease or condition resulting in death) **Physician** 10512 /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) bed ☐Yes 2 No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2□ No 2 No 1 Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiger? Be 26. Place of Death (Check only one) examiner? 1 res 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient 2 2 ER/Outpatient 3□ DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manney of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Diractor: A d in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and tyle of certifier 29c. License number 29d. Date signed (Month, Day, Year) IIIe of death (Item 23a) (Type, 31. Date filed (Month, Day, Year)
MAR 2 5 2005 22. Registrar's Signature State

Registrar

ORIGINAL

			For Stete Registrer	State of M	•	epartment of the control of the cont		Re	eg. No.2 0 0 5	12066	
	Dhysisi	20	1. Decedent's Name (First, Middle	, Last)				2. Date of Deat Month		3. Time of Death	
	Physici /Medic			Landon	Pratt	Jr		March 3	0, 2005	7:13pm M	
	Examin	er	4a. Fecility Name (If not institution	-			or Location of Death		4c. County of Dea		
			Shady Grove A				<pre><ville< pre=""></ville<></pre>	1-6: (6:0)	Montgo		
	Funeral Director		5. Social Security Number 217=70-3443	6. Sex 7. A 1X M 2 ☐ F	ge (In yrs. last birth) 39 Yr	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sep 13.	^{Yee} r) 9. Bi	othplace (State or Foreign Sountry) aryland	
	P .		Usual Residence of Decedent					, <u>,</u> ,			
	darylar f ehow	ō	10a. State 10b. County Maryland Frede	erick	10c. City, Town of Mont	or Location COVIA				10d. Inside City Limits 1 ☐ Yes 2 ☑ Xio	
	3a or 28e-	i Director	10e. Street and Number 4129 Lynn Burk	te Road		10f. Zip Code	21770	11	0g. Citizen of What C	,	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "netural", or itema 23a or 28e-f ehow or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 □ Divorced	If Yes, Give] No	13. Was Decedent of I If Yes, specify Cub		pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Wh Specify:		
Ö	hour turai		15, Decedent	Year or Dates		ecedent's Usual Occu	nation		16b. Kind of Business		
Maryland 21215-0036	filed within 72 Hygiene. hther than "nei ent, the Wedic	Completed	(Specify only highes Elementary/Secondary (0-12) 12		Distributor						
b	e filec al Hyg l othe vent,	BeC	17. Father's Name (First, Middle,					ne (First, Middle, A			
rylar	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	70	-	Landon	Pratt	Sr Mailing Address (Street	Barbara		dcliffe	Badger	
	and 2 sl ealth and m 27 is r		Phillip L. Prat			9 Longwood					
ore,	as 1 a of Hei fitem	li	20a. Method of Disposition	2 Clarent from State	_ cemetery,	isposition (Name of crematory or other pla	ce)		20c. Location - City o		
Ĕ	Pages ment of h ant: If ite ury or o		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S)	pecify)	" Smithst	ourg Cremat	tory Apr	4, 2005	Smithsbur	g, Maryland	
Baltimore,	permit. Page Department of Important: If eny injury or		21. Sign turn of Funeral Service I	Dow	M00706	22. Name and Addre Keeney & 106 East (& Basford	P.A. Fur Freder	neral Home ick. Marvl	and 21701	
l.	Pnysician /Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. bact	erial p	enter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
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<u>,</u>	sician and burial-translt	Examiner	that initiated events resulting in death) Last	C.	s a consequence of)					years	
8760,	cate be exc physician a the burial	dicai		d							
.O. Box 6	eath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		e of pregnancy 2 Fetal death at time of death	23d. Date of de Month	23d. Date of delivery Month Day Year				
Φ.	quires that the d n signed by the uld be detached	by	Part II. Other significant condition		but not resulting in t	ne underlying cause gr	23e. Did tob		to the cause of death?		
Records,	The law requir ate has been s page 2 should	Completed						24a. Was ar autops perform 1 Yes 2	v prior to		
of Vital	Physicien: Th this certificate ral director, pag	Bec	25. Was case referred to medical examiner?					th (Check only one	9)		
) T	S S	2	1 ☐ Yes Ø No	Hospital: Inpa	tient 2 ER/Outp	atient 3 DOA Ott	her: 4 Nursing Ho	ome 5 Reside	nce 6 Other (Spe	ecify)	
U O	ifter ine		27. Manner of Death Netural 5 ☐ Pendin	28a. Date of In (Month, L	jury 28b. Tin lay Year) Inju	iry Wo	rk?	28d. Describe ho	w injury occurred		
Division	i or Attending Ph after death. Director: After th In by the funeral	licati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural R								
Ρį	0 = 5 =	27. Manner of Death State of Injury 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Injury 28c. Injury at Inju									
	To the Hospital or within 24 hours after To the Funerel Director completely filled in the Funerel Director of the Funerel Dire	29a. Certifier (Check only one) 29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state of the cause(s) and the caus									
	To t withi To t	Σ	29b. Signature and title of certifier Plicas	J. Mistr	7 MD	29c. Licen:	9738		Od. Date signed (Mon Murch 31		
_				ristry 9		pe, Print) dical ce	inter Dr	rive Ru	ckville,	MO 20850	
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 7 2	005 2. Regis	trar's Signature	ale					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 04, 2005 7:45 A. Sister Editha Piedmont /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Emmitsburg,

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. St. Vincent Care Center Frederick 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2√2 F 12, 1912 Virginia Sept. 92 Director 042-44-9353 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show Exercises rount be notified at 1 Yes 2 No Director Emmitsburg MD Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with Items 23a or U.S.A. Funeral 21727 335 South Seton Avenue death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene.
em 27 is marked other then "naturel", or Ite then traumatic event, the Modical Exertical. 1 Never Married 2 ☐ Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Religious Community College (1-4or 5+) Elementary/Secondary (0-12) Daughters of Charity College 5+ Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Audrey Teresa Hopkins Francis Stephen Piedmont 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 to Department of Health are Important: If Item 27 is any injury or other traus. 333 S. Seton Avenue, Emmitsburg, MD Sister Camilla Harant Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ST. JOSEPH'S P.H,. 4/7/2005 EMMITSBURG, MD. 21727 *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME MD. 21727 W. MAIN ST., EMMITSBURG, 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) Physician /Medical Due to (or as-a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) Box 68760 Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 X No 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Ď page 2 should be 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed? Yes 200 No certificate has 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one funeral director. Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 310 S. SETON AVE., EMMITSBURG, MD. 21727 ALAN CARROLL, M.D., 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 0 7 2005

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2005 William Thomas Ross March 10:20 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Eastpoint Nursing & Rehab. Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 XM 2 □ F Months Days Hours Min. Director <u>579-58-2115</u> 4, Wash., DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28e-f show traumatic event, the Madical Examinar must be nutified at 1 X Yes 2 ☐ No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1046 Old North Point Road 21224 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinat once. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 ₩Widowed 4 Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Auto Mechanic Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Ross Sarah Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Thomas Ross, Jr./Son 3215A Birdwell Ct., Laurel, MD 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ³ 4 □ Donation 5 □ Other (Specify) 3/24/2005 Washington National Suitland, MD 22. Name and Address of Facility 21. Signature of Fulfieral Service Licensee Stewart Funeral Home levou 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or con 11 on resulting in death) Physician Septicemia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hypotension Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, been signe should be c þ Dehydration 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Malnutrition 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate End Stage Huntington's Chorea 2 XNo 1 Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐XNo 3□ DOA this After thi 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗆 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 🗌 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 T Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner sta 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) D11150 March 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) MAR 2 5 2005

Melito M. Torres, M.D. 441 S. Ellwood Ave., Baltimore, MD Registrar's Signature

			Olate of Wil	aryland	_	rtificate o		id ivieritai i	Reg. No.	05	12069		
Phys	ician	1. Decedent's Name (First, Middle, Le	2. Date of Month	Death Day	Year	3. Time of Death							
	dical	FREDERI		ROBEF	RTS			April	1,	2005	8:40 P.M.		
Exan	niner	4a. Facility Name (If not institution, give		_			-	, or Location of De		ty of Deatl			
		McCready Memori 5. Social Security Number 6.5			në thinth day (If Under 1 Ye		sfield		erset			
Funeral Director			7. Age 1 M 2 □ F	e (In yrs. las 75	Yrs.	Months Da	ys Hours	Hrs. 8. Date of (Month, Aug.	Birth Day, Year) 9. Birthplace (State or Foreign Country) 12, 1929 Massachusetts				
		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits		
Mary e-f sh	ģ	Maryland Somers				1 ☐ Yes 2 Ҕ No							
th the	Director	10e. Street and Number				10f. Zip Cod	le		10g. Citizen of	What Co	Country?		
th wil	<u> </u>	4304 Jacksonville	e Road	Road 2:			21817		U	U.S.A.			
or dea	Funeral	11. Marital Status	12. Was Decedent & Armed Forces?		13. V	Was Decedent f Yes, specify C	of Hispanic Origin Suban, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No- 14. Ra BI	ace - Amer ack, White	rican Indian, e, etc.		
Baltimore, Maryland 21215-0020 bemit. Pages I and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Mental Hygiene. mportant: If item 27 is marked other then "natural", or items 23e or 28e-f show nny injury or other traumatic event, the Medical Examinations investinated.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		1 □ Yes 2 ₫				Spec	ity: Wh	ite		
15-(Completed	15. Decedent's E (Specify only highest gra	ducation ade co <i>mpleted)</i>		16a. Deced	lent's Usual Oc kind of work do	cupation one during most of tired)	working	16b. Kind of		_		
Mithir Mithir	E d	Elementary/Secondary (0-12)	College (1-4or 5)+)					State of Maryland Dept. of Corrections				
filed wi Hygien Wher the	ပိ	12 17. Father's Name (First, Middle, Last	2		Recreation Director			Name (First, Mide			TIECCIONS		
e d la b	To Be	Frederick H. Rok						othy Ten					
Aary 2 shoul 1 and Me is mark raumati	<u> </u>	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	ng Address (Str	eet and Number o	r Rural Route Nur	nber, City or Tow	n, State, Z	State, Zip Code)		
1 and 2 1 and 2 Health a em 27 is		Helen Roberts (V	Wife)		4304	Jackso	nville R	oad - Cr	isfield,	MD	MD 21817		
Ore, es 1 a of Hei of Hei r othe		20a. Method of Disposition		20b. Plac	Place of Disposition (Name of cemetery, crematory or other place)			Date		20c. Location - City or To			
Baltimore, Marylk permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	JRemoval from State (y)			y Crema		4/4/05	Salis	Salisbury, MD			
mit.	3	21. Signature of Funeral Service Lices	nsee	/			dress of Facility	D					
D 82 = 9:	ä	Bradshaw & Sons Funeral Home Robert H. Bradshaw Jr. 306 W. Min St Crisfield, Mt) 218 23a. Partl. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
		23a. Part1. Enter the disease, or com	plications that cause	the death.	Do not ente	er the mode of	dying, such as cer	rdiac or respirator	arrest,	23.01	Approximate Interval Between		
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/Medica Examine		Immediate Cause (Final disease or condition	a		AS	CVD				i			
- LACITION		resulting in death)		Due to (or a	is e conseq	uence of):				1			
ted nsit	Examiner	_	b			,							
execu n end ial-tra	Exal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	'	Due to (or a	is a conseq	uence of):				ļ I			
68 / 6U, ficate be executed physician end as the burial-transit	cai	triat initiated events	c	Due to (or as a consequence of):									
OTGS, P.O. BOX 68/6U, requires that the death certificate be executed requires that the death certificate be executed even signed by the attending physician end hould be detached for use as the burial-transit	Medicai	resulting in death) Last			i								
BOX 68 leath certifics attending pt			d										
e dea the at	Physician/	Part II. Other significent conditions of	23b. D	23b. Did tobecco use contribute to the ceuse of death?									
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The law rate has be page 2 st	Completed							494	1700 mm - 1700 m 1700 mm -	20	f death?		
		25. Was case referred to medical							JYes 2XNc	1	□ Yes 2□ No		
OT VICE Physician: rthis certific real director,	o Be	examiner?	Hospital: 1XX Inpatier	nt 2 🗆 E	R/Outpatient	t 3□ DOA	Othor	Death Check onling Home 5 Re		har /Casa	:6.1		
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UNISION of all or Attending P affect death. Director: Affect din by the funers	tifica	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Inju	iry - At hom	e, farm, stre	et, factory, office	ce	28f. Location	(Street and Num Town, State)	ber or Ru	ral Route Number,		
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		D 48098 4/1/2							1200	5			
		30. Name and address of person who	•						- 31				
		Vijay Karumbunatl				Highway	- Crisf	ield, MD	21817				
	tate	- OCON NV 44 M - W 10											
Regis	ual	APR U 7	COOS STATE	yes s	5 19		10						

DHMH 16 Rev 6/95

			For 1 State		aryland / Dep	artment of Health ar rtificate of Death	nd Mental Hyg	giene	10070				
			Registrar 1. Decedent's Name (First, Middle,	(aat)	Ce	Tillicate of Death	2. Date of Dea	Reg. No ⊱ 💟 🔾	2 U / U				
	Physici	ian	Martha C. Robe				Month	Day Year	3. Time of Death 2:55 P M				
No.	/Medio		4a. Facility Name (If not institution,			4h City Town or Landian of I	March_						
1	Examir	ner				4b. City, Town, or Location of I	Death						
Н	F		Clearview Nursing 5. Social Security Number 6		ge (In yrs. last birthday)	Hagerstown If Under 1 Year If Under 24	Hrs. 8 Date of Birth	Washing	rthplace (State or Foreign country)				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 North Days 1 North Days 1 November 25,1916 1 November 25,1916										
	/land		10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Itams 23a or 28e-1 show any injury or other treumatic event, the Medical Evair are must be indiffied at ance.	to	MD Washing	ton			1 □Yes 2 XNo						
	r 28c	Funeral Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What C	ountry?				
	h wit	E C	14832 Weller B	Road		21750		USA					
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No-						
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Mai	12 sho h and 7 Is ma treum		19a. Informant's Name/Relationship						ZIP Code)				
	1 and 1 dealt 1 sm 2 ther		William Winn/Sor	<u> </u>	20b. Place of Dispo	Weller Road Ha		ZI/DU 20c. Location - City or	Town State				
Baltimore,	in it of l		1 Burial 2 XCremation 3	☐Removal from State	cemetery, crei	matory`or other place)							
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Bal	permit. Departr Importa any inji		21 Signature Funeral Service Li	sensee (M)		2. Name and Address of Facility		Main Stre					
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1	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):				Chronic Chronic .				
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O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a' 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	Date of delivery Month Day Year				
ds, P.O.	w requires that to been signed by should be detact	þ	Part II. Other significant conditions contributing to death but not resulting in the uncertying cause given in Part I.										
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I Records,		Completed	24a. Was an autopsy prior to death? 1 □ Yes 2 1 □ Yes										
Vital	cian: ertific	Be	25. Was case referred to medical examiner?				Death (Check only on	18)					
of \	Physician: this certificaral director, p	2	1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/Outpatier		ng Home 5 ☐ Reside	ence 6 □Other (Spe	ocify)				
	ding h. After fune	atlon:	27. Manner of Death 1	28a. Date of Inju (Month, Da tion	y Year) 28b. Time o	f 28c. Injury at Work? M 1 Yes 2 No		ow injury occurred					
Division		Certification;	3 Suicide 6 Could no 4 Homicide determin	289. Place of inj	DB One Disease Injury. At home form direct feeters office								
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	To the within 3	Me	29b. Signature and title of certifier			29c. License number		9d. Date signed (Moni	th, Day, Year)				
				ND MO		D 006222	3	4/1/05	•				
			30. Name and address of person with	no completed cause of o	eath (Item 23a) (Type.	Print)	3	me Ha	nestown				
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amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 105 TI State of Maryland / Department of Health and Mental Hygiene 1- Registrar 3/28/05 amended item #1/wch@artificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Donald Robert Stewart Day Month Year **Physician** Donald Stewart 1430 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY tf Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days | Hours | Min. JAN 13, 1939 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex **Funeral** Months 1**X** M 2□F 222-22-3891 DELAWARE 66 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County r then "natural", or Items 23e or 28e-f show the Medical Examinar must be notified at 1X Yes 2 No DELMAR **MARYLAND** WICOMICO Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21875 AMERICA 8891 BI STATE BLVD filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No tf Yes, Give Year or Dates1 962-64 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) AGRICULTURE Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then FARMER 9YRS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Pages 1 and 2 should be nent of Health and Mental MILDRED EVELYN PASSWATERS ROBERT EARL STEWART 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DELAWARE 19956 2251 JAMI AVE. LAUREL, PATSY J. LECATES - SISTER or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State X Burial 2 ☐ Cremation 3/29/05 BLADES, DELAWARE BLADES CEMETERY 1 4 □ Donation 25 □9 ther (Specify) 21. Signature of Funera Service Licenses 22. Name and Address of Facility WATSON-YATES FUNERAL HOME, INC. DELAWARE 19973 SEAFORD, Part1. Enter the disease or complications that shock, or heart failure, List only one cause on Approximate Interval Between Onset and Death aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner espiralor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a co Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 No 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident after death Director: completely tilled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 29a. Certifier 🔙 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicet Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24/05 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 58mC amon. Mo 31. Date filed (Month, Day, Year) MAR 2 8 2005 Agistrar's Signature 32. State Registrar

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DAVID M. SCHELL, Jr. 05-02017 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. RKD State of Maryland / Department of Health and Mental Hygiene [] 1- State Registrar Amend Item#4c, per me, QACHD, 3/24/05, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MÄRCH 20, 2005' **Physician** 12:30A. M DAVID MICHAEL SCHELL, JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** QUEEN- ANNES CHESTERTOWN CHESTER RIVER HOSPITAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | APRIL 7, 1981 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** MARYLAND 1X M 2□ F Yrs 23 222-72-0903 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State irel', or Items 23e or 28a-f ahov Examiner must be notified at 1 ☐ Yes 2 No CENTREVILLE QUEEN ANNE MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21617 121 GADD DRIVE Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 XNever Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ 3 Widowed 4 Divorced naturel, Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) then Hygiene, Elementary/Secondary (0-12) College (1-4or 5+) PLUMBING & HEATING PLUMBER permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: If item 27 Is marked other th eny injury or other traumatic event, the once. 12 -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BETTY ANN McDADE DAVID MICHAEL SCHELL, SR. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1003 SAGE AVE., READING, PA 19605 DAVID M.SCHELL, SR./ FATHER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CENTER, * 4 ☐ Donation 5 ☐ Other (Specify) 3-23-2005 STEVENSVILLE, MD 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Multiple Injuries /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate ba executed burial-tran Due to (or as a consequence of): Box 68760, attending physician Physiclan/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check on one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 ☐ No 2 in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day 28b. Time of 27. Manner of Death e Hospital or Attending P 24 hours after death. e Funerel Director: After t Certification: briver of motor vehicle that collided Injury 1 Natural 5 Pending 1 Tes investigation 3-19-05 11:49 28f. Location (Street and Number or Rural Route Number, City or Town, State) Rt. 3cc - Felton School Rd 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Koad Sudjersville ND 24 hours a t 🗌 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME MARCH 21,2005 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)

111 Penn Street Baltimore, Maryland 21201

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day

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Registra s Signature

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ician dical miner steering by by solar transitions. To Be Completed by Physician/Medical Examiner that intering the burner as the burner and the calculations of the steering by Physician/Medical Examiner that intering the burner and the steering by Physician/Medical Examiner and the steering by Physician/Medical Examiner and the steering by Physician American and the	21. Signature of Fund I Service	a Lice vee					Mattingley- ardtown, Mar			l Home, P
ician dical integrations are the area of t	23a. Part. Enter the disease, o shock, or heart failure. Lis	or complications tha	it coused the dea	th. Do not ente	er the mode of	dying, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
resulting result	mmediate Cause (Final	it only one cause of	UN G	. (ANCE	- 6				Onset and Dea
Sequentification: Sequently the funeral director, page 2 should be detached for use as the burial-transit that unities are the purishment of the form	disease or condition esulting in death)	a. Due	to (or as a consec							6 11101
fication: To Be Completed by Physician/Medical Examination: To Be Completed by Physician Physici	Coquentially list conditions	b								
fication: To Be Completed by Physician/Medical Example 2 3:0010 De detaction of use as me pure as the	sequentially list conditions, any, leading to immediate ause. Enter Underlying	Due 1	to (or as a consec	quence of):						
In the second of the second	hat initiated events esulting in death) Last	C								
Ill cation in the completed by Physician/Medication in the cation in the	southing in death) cast	Due	to (or as a consec	quence of):						
Il FEMA 23b. Was 10 and		d							-	
fication: To Be Completed by Physis 25. Was a 27. Was 1 1 2 2. Was 3 3 3 3	F FEMALE:	23c If yes	outcome of pregn	2001						
fication: To Be Completed by Physis 10.0 1.0	3b. Was decedent pregnant in the past 12 months?	1 Live	e birth 2 Feta	al déath 3 🗌	Ectopic pregna Other <i>(specify</i>			I	ate of delive Month	ry Day Yea
fication: To Be Completed by 19 19 19 19 19 19 19 19 19 19 19 19 19	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unl		16a(i) 3[Curer (specify	/				
fication; To Be Completed	art II. Other significant conditi	tions contributing to	death but not res	sulting in the ur	nderlying cause	given in Part I.	23e. Did	tobacco use co	ntribute to th	e cause of deat
25. Was 27. Man 27.	ATRIAL		TTER				1 🗆	Yes 2□No	3 ☐ Prob	ably 4 Mink
25. Was exam 1 27. Mann 1 28. Was 3 3 3 3		•					24a. Wa	24h	Mora autor	osy findings ava
on the funeral director of the							auto	opsy formed?	prior to cor death?	npletion of caus
1 27. Manual 1 22.	F 144						1 ☐ Yes	2 X No	1 ☐ Yes	2 ∑ No
27. Manr 1 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	 Was case referred to medical examiner? Yes 2 No 	11 3-1	W	3500		Other	Death (Check only			
illed in by the func 2 Certification	II TOS ZIMINO	1)	Inpatient 2 ☐ te of Injury onth, Day Year)	28b. Time of	T 3LI DOA	4 🔲 Nursi	ng Home 5 ☐ Res 28d. Describe	how injury occu		′)
Certifical 3 (1) 19 19 19 19 19 19 19 19 19 19 19 19 19	7. Manner of Death	ling (Mo	onth, Day Year)	Injury		njury at Work? I □ Yes 2 □ No		. ,		
See 29a. Cer	7. Manner of Death 1 XNatural 5 ☐ Pendi	not be 28e. Pla	ice of Injury - At h	ome, farm, stre	eet, factory, offi	ce	28f. Location	(Street and Nun	ber or Rura	l Route Number
29a. Cer	7. Manner of Death 1 XNatural 5 Pendi 2 Accident invest 3 Suicide 6 Could	bui	ilding, etc. (Speci	fy)	•		City or To	wn, State)		
(Ch	7. Manner of Death 1 XNatural 5 Pendi 2 Accident invest		basis of examina	owledge, death	occurred at the	e time, date and p	place, and due to the occurred at the time	cause(s) and n	nanner as st	ated. the cause(s)
Wedical (Ch. on 29b. Sign	7. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 1 Certifier (Check only 2 Medicel	of Examiner: On the						29d. Date sign	ed (Mogth I	Day Vaar)
290. 519	7. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 19a. Certifier (Check only one) 7. Manner of Death 5 Pendi invest 6 Could determ 1 Certifyi 2 Medicel	el Examiner: On the and ma	anner stated.		200 1 10	ense numbor		Zou. Date Sign	iou (MUNITH, L	-uy, rear/
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30. Nam N e	7. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 12 Certifier (Check only one) 9b. Signature and tittle of certifier	ier	m. D:		D-	-28281		MARCH	+ 25,	2005

		1 - For State Registrar	State of Maryl		artment of H tificate of L			iene	5	2075
Physic	ion	1. Decedent's Name (First, Middle,	Last)				2. Date of Deat Month	h Day	Year	3. Time of Death
/Med		Para	lee Juanita Sl	harp			March 28	,	1001	7:50 Рм
Exami	ner	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death	ו	4c. County of		
		45614 Rutherford B1	.vd.		Great Mil	1s		Saint N	Mary's	
Funeral Director		5. Social Security Number 234-52-4947	5. Sex 7. Age (In) 1 ☐ M 2 XXF	yrs. last birthday) 104 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, September			ace (State or Foreign ry) Carolina
P .		Usual Residence of Decedent								
how	_	10a. State 10b. County	10c.	City, Town or Lo	cation				10	d. Inside City Limits
e Ma	Directo	Maryland Saint M	lary's	Great Mi	l1s_					1 ☐ Yes 2XXNo
th th or 28	Jire	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Countr	y?
23a		45614 Rutherford B1	vd.		20634			USA		
r dea	Funerai	11. Marital Status	12. Was Decedent Ever i Armed Forces?	in U.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (S	pecify Yes or No-		- America	
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "natural", or flems 23a or 28a-f show matic event, the Marical Exc. other matic event, the Marical Exc.	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 🖾 Widowed 4 ☐ Divorced				Specify:	- 1	Specify:		
2 hou		15. Decedent's	Education	16a. Deced	lent's Usual Occupa	tion		16b. Kind of Bus	siness/Indu	ıstry
212 27 min 27 mi	Completed	(Specify only highest Elementary/Secondary (0-12)	<u> </u>	(Give	kind of work done d DO NOT use retired)	uring most of wor	king			,
d with	E	8	College (1-4or 5+)	Н	omemaker			Own Home	2	
othe other,	BeC	17. Father's Name (First, Middle, La	ist)			18. Mother's Nan	ne (First, Middle, M			
arylan should be nd Mental marked o	ToB	Alfred L. Boston				Beulah L	. Carter			
W ~ ~ ~ ~		19a. Informant's Name/Relationshi	o (Type, Print)	19b. Mailir	g Address (Street a	nd Number or Ru	ral Route Number,	City or Town, S	State, Zip C	Pode)
		Judy A. Cowan / Dau	ghter	45614	Rutherford	Blvd., Gre	eat Mills,	Maryland	20634	
Baltimore, bermit. Pages 1 ar Department of Hea mportant: If item; any injury or other ance.		20a. Method of Disposition	20	b. Place of Dispo			Date 2	Oc. Location - (n, State
Pages nent of l int: If its		1 🕅 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			orial Park	. " " " "	ril 2005 Ca	airo, Wes	t Viro	inia
Baltimory permit. Pages Department of H Important: If ite any injury or of once.		21. Signature of Funer Septice Li		22	. Name and Address	s of Facility		-		IIII
		fule	Jesmeny -		attingley-Ga D. Box 270,					
10.7		23a. Parta. Enter the disease, or c	omplications that caused the c						- /	Approximate Interval Between
Pnysician		shock, or heart failure. List or Immediate Cause (Final	ny one cause on each line.	Ais	u. a	ut L	ailure	2	· ·	Onset and Death
/Medical	_	disease or condition resulting in death)	a OV O E	sequence of):	reed	* 1	20100		_	
Examiner			Hill	ertens	5 -					
	ē	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying	b. Oue o (or as alcon.	sequence of):	0.				-	
uted d ansit	E .	Cause (Disease or injury that initiated events	hu not	myroid	15m					
exec n an ial-tr	Examin	resulting in death) Last	Due to (1r is a con:							
64 / 6U, cate be executed physician and the burial-transit	dicai		d 5 0	re						
	edi			1200	717704			10		
Geath certifice attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date	of delivery	,
death death death	icia	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 2□F 4□Pregnant at time (Ectopic pregnancy Other (specify)			Mont	th D	Day Year
	hys	9 Unknown	9□ Unknown							
- 4 P B	by P	Part II. Other significant condition	s contributing to death but not	resulting in the ur	iderlying cause give	n in Part I.	23e. Did tob	acco use contril	bute to the	cause of death?
HeCOrdS, he law requires t e has been signe tge 2 should be o							1 ☐ Ye	s 2 1 No 3	3 🔲 Probab	bly 4 🗀 Unknown
COLD Iw requir s been si s should I	jet						24a. Was an	24b. W	ere autops	sy findings available
The lav	ompieted						autopsy perform	ed? pr	ior to comp eath?	pletion of cause of
	O O	25. Was case referred to medical				00 Place of Dec			☐Yes 2	LINO
	0 0	examiner?	Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatien		The same of the sa	th (Check only one ome 5 Resider		(0	
Phy Phy or this and d	I	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury	at	28d. Describe how	v injury occurre	d (Specify)	
on oding the the funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Year	r) Injury	Work'	? es 2 □ No				
DIVISION I or Attending after death. Director: Afte	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of Injury - A	At home, farm, stre	eet, factory, office		28f. Location (Str.	eet and Numbe	r or Rural F	Route Number.
UIVISION of all or Attending Falls after death. Il Director; After din by the funeral of in b	Certification:	4 Hamicide determin	building, etc. (Sp	ecify)			City or Town,	State)		
To the Hospital or within 24 hours aft To the Funeral Dis completely filled in		29a. Certifier 1 Certifying	Physicien: To the best of my	knowledge, death	occurred at the time	e, date and place,	and due to the ca	use(s) and man	ner as stat	.ed.
ne Ho n 24 h ne Fu letely	edicai	(Check only 2 Medicel Ex	deminer: On the basis of examiner and manner stated.	nination and/or inv	estigation, in my opi	inion, death occui	rred at the time, da	te and place, ar	nd due to th	ne cause(s)
To th withir To th	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed	(Month, Da	ay, Year)
540		NUM	et us		DS	302	1	3-70	9-1	05
20		30. Name and address of person w	completed cause of death (Item 23a) (Type. I	Print)					
0		Manoj Panwala, M.D.				ket Drive.	Charlotte	Hall. Ma	ryland	20622
St	ate	31. Date filed (Month, Day, Year)	32. Regis ar's Si	gnature						
Regist		MAK 3	0 2005	w St	Buch					

				For Amend Item 24 State of V	42 y langs/42 ep		ith and Me	ntal Hygie	-	12076
		Physic /Medi		1. Decedent's Name (First, Middle, Last) HARRY E • STRAWBRID			2.	Date of Death	Day 2005	3. Time of Death
		Exami		4a. Facility Name (If not institution, give street and number Upper Chesapeake Medical Center	or)	4b. City, Town, or Loca Be1			4c. County of Deat Harfo	
		Funeral Director		217–22–8691 ¹\X™ 2□F	Age (In yrs. last birthday) 78 Yrs.		ours Min.	Date of Birth (Month, Day, Ye 1/28/192	17	nplace (State or Foreign untry) ryland
		death with the Maryland ms 23a or 28a-f show Imust be notified at	ctor	Usual Residence of Decedent 10a. State	10c. City, Town or Lo	rlington				10d. Inside City Limits 1 ☐ Yes 2 No
		3a or 28	i Director	10e. Street and Number 2031 Glen Cove Road		10f. Zip Code 21034		10g.	Citizen of What Co	
640	920	s 1 and 2 should be filed within 72 hours after death with the Marylan ff Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, Ite Medical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 XYes 2 If Yes, 6:00 Year or Dates	s? TNo	Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2 ▼No Spe	ic Origin? (Specification) ic Origin? (Specification) ic Original (Specification) ic Origin? (Specification) ic Origin. (Specification) ic Origin? (Specification) ic Origin? (Specification) ic Origin. (Spec	y Yes or No- an, etc.)	14. Race - Ame Black, White	rican Indian,
950 3	altimore, Maryland 21215-0036	ithin 72 horange.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)	16a. Dece (Give life.	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working		b. Kind of Business/I	٠
193	nd 21	be filed water that dother the	Be	Unknown 17. Father's Name (First, Middle, Last)			Mother's Name (F	irst, Middle, Maid		tion
	aryla	should the	To	Lindley J. Strawbride 19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and N	Bertha lumber or Rural R			ip Code)
105	e, Ma	1 and 2 Health a em 27 ls ther trai		Robert W. Strawgridge		Liberty Gro		, Colora		917
123/05	Itimor	t. Page ntment o rtant: If njury or		1 № Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	St. Paul	natory or other place) 'S Cemetery 2. Name and Address of F	3/29/2		Pylesville	
(2)	Ba	Depar Impo any Ir		Jephen Poter	relief He	arkins Funeral	Home, Inc.		St.,Delta,	PA 17314
		Physician /Medical			line.	er the mode of dying, such		espiratory arrest,		Approximate Interval Between Onset and Death 13 Days
Y#187565	68760,	certificate be executed anding physician and se as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	e a consequence of):	OSÌS				20 years
Harr	.O. Box 6	death e atten ed for u	Physician/Medi		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of deli-	very Day Year
0)	rds, P	requires that the leen signed by th hould be detache	by	Part II. Other significant conditions contributing to death Negrotizing Pneume	S= 0 -	nderlying cause given in F	Part I.		1.7	the cause of death?
10/9	al Record	as b	Completed	Hypertension, Hu Atrial Fibrillation	perlipide	mia		24a. Was an autopsy performed 1 ☐ Yes 2XX	prior to c	opsy findings available ompletion of cause of
awbr	ion of Vital	ng Phye Iter this Ineral dii	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 npa 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of In (Month, D		t 3 DOA Other: 4	28d		6 ⊡Other (Speciality)	ify)
2	Division	or Atter after des Director	Certification:	3 Suicide 6 Could not be 28e, Place of I	njury - At home, farm, str atc. <i>(Specify)</i>	eet, factory, office	28f.	Location (Street City or Town, St	and Number or Rui ate)	ral Route Number,
5		To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner:	of examination and/or inv	n occurred at the time, dat vestigation, in my opinion,	te and place, and , death occurred a	due to the cause at the time, date a	e(s) and manner as	stated. to the cause(s)
		To the within To the Comple	Me	29b. Signature and title of certifier		29c. License num	210	M	Date signed (Month)	
	7	3		30. Name and address of person who completed cause of Mario Zamiva 500 U	death (Item 23a) (Type,	Print) Decke Drive	Bel Ari	- m/2	1014	AUUS
		Sta Registr	. 9	31. Date filed (Month, Day, Year) APR 0 8 2005 APR 0 8 2005	trar's Signature	Print) Decke Drive	[Part Part	1-60	,-,,	

State of Maryland / Department of Health and Mental Hygiene Reg. No. U 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Month : 20Am /Medical Rose L. Suber 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince Georges Riverdale Crescent City Nursing Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□M 2፟ F 87 380-30-1729 Yrs. July 12, 1917 South Carolina Director Usuel Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryle Depertment of Health end Mentel Ptygiene. Important: If tem 27 is merked other then "natural", or items 23a or 28a-1 show any injury or other traumetic event, the Medical Examiner must be notified at one. Prince George Riverdale Maryland 11√1 Yes 2 □ No. Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4409 East West Highway 20737 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black δ 3 X Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6th Housewife Domestic 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Feddie Boyd Marie Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Cox/Niece 6429 Old Landover Rd; Landover, MD. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 3/29/05 Suitland, MD. Lincoln Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility
Alexander S. Pope Funeral Homes, P.A. 5538 Marlboro Pike/Forestville, Md. 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Congestive Heart Failure. Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificete be executed ettending physician and for use es the bunel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or es e consequence ol): Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sino Condivuarcular Disease, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Š Atheroschafic varale Be Completed 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2KNo 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation nerel Director: A filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerel C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only 29b. Signature and title of 29d. Date signed (Month, Day, Year) D48213 03-24-2005 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Neelam Ashai, M.D. 4410 74th Ave. Landover Hills, MD. 20784 32. Registrar's Signature 3 2005 State Registrar

3/1

DHMH 16 Rev 6/95

Lloyd F. Tweesy 012-22-1267

100 #75 34a

		1- State Amend Items Registrar		ryland/ r Verb	Dep	artment of C845 rtificate of	Tealth and Death			F-1-2	
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Las Lloyd Frase 4a. Facility Name (If not institution, give	er Tweed	dy		4b. City, Town,	or Location of De	2. Date of Dea Month MARCH	Day Francis	Year 2005 by of Deeth	3. Time of Death
LAdiiii	iei	Peninsula Regiona	1 medica		tu		54/1364	M		Vicamie	
Funeral Director		5. Social Security Number 6. Sr 012–22–1267	9x 7. Age ▼ M 2□ F 7	(In yrs. last l	Yrs.	If Under 1 Year Months Days			y, Year)		ace (State or Foreign try) LNOIS
Fig. MidFyldfild Z I Z I D-UUSO s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, itam 27 is marked other than "natural", or itams 23e or 28e-f show other traumatic svent, the Madical Eventinat Langitified at	Director	10a. State 10b. County Maryland Worcest 10e. Street and Number	er	10c. City, To Snow					10g. Citizen of		od. Inside City Limits 1 ☐ Yes 2 🛣 No
ath with	raiD	3522 Figgs Landin	g Rd.			21863			USA		
urs after der al', or Itams	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates:	0		Was Decedent of lift Yes, specify Cub 1 ☐ Yes 2 🛱 No		(Specify Yes or No- erto Rican, etc.)	14. Ra Bla Speci	ce - America ack, White, e	
Z I Z I D-UUSO d within 72 hours atl giene ar than "natural", or tha Medical Evanti	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5-		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of v	vorking	16b. Kind of E	Business/Ind	ustry
filed w Hygier Athar th		12 17. Father's Name (First, Middle, Last)	4	T	'ele	<i>i</i> sion D <u>i</u>		lame (First, Middle.		micat:	ions
Maryland d 2 should be file th and Mental Hy 7 Is marked oth traumatic svant	To Be	Albert William Tw	eedy					ie Mintur		,	
2 should and Men Is marke		19a. Informant's Name/Relationship (7	ype, Print)	19	b. Mailir	ng Address (Stree	·	Rural Route Numbe			Code)
dillinore, IN mit. Pages 1 and 2 partment of Health portant: If itam 27 y injury or other tru		Alice Tweedy/wife 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	Removal from State	20b. Place cemet	of Dispo	Piggs I esition (Name of matory or other pla	ce)	Rd., Snow	Hill, 20c. Location	MD 218	263 vn, State
Dallinore, permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen:	/	Sali) 22 H	y Cremat ame and Addr Olloway	ery Ess of Facility Funeral	26/2005 Home Prot	fession	bury, al Ass	sociation
Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition			TIOL BIIL	01 Snow er the mode of dyi	ng, such as card		ary, MD		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	consequence	e of):	prem /	177101	majne			e L
te be executed sysician and eburial-transit	i Examiner	Sequentially list conditions, if any leading to mindeled cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a								
9 % 9	Medicai	IF FEMALE:	d.						-		
y the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal dea		Ectopic pregnanc Other (specify) _	у			ate of deliver onth [y Day Year
he law requires that he has been signed b sge 2 should be deta	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting	in the u	nderlying cause gr	ven in Part I.				e cause of death?
	Completed							24a. Was a autops perfor 1 ☐ Yes	sy med?	Were autop prior to com death? 1 \(\text{Yes} \) 2	sy findings available pletion of cause of
	o Be	25. Was case referred to medical examiner? ▼ Yes 2 No	Hospital:	t 2 ER/C	Outnation	t 3 DOA Ott	age	eath <i>(Check only or</i> Home 5 Resid			
Attending Physic death. actor: After this by the funeral di	ation: T	27. Manner of Death 12. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b	Time of Injury	28c. Inju Wo	ry at	28d. Describe h			
D B C D D	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, (Specify)	farm, str	eet, factory, office		28f. Location (S City or Town	treet and Numi n, State)	ber or Rural	Route Number,
To the Hospital or At within 24 hours after or To tha Funaral Dirac completely filled in by	edicai	(Check only 2 Medical Exam	rsician: To the best of iner: On the basis of and manner stat	examination a	ge, death ind/or inv	estigation, in my	opinion, death oc	curred at the time, d	late and place,	and due to t	the cause(s)
Som To	W	29b. Signature and title of certifier	lug			D Z	4872	2	29d. Date signe	4/6	say, Year)
12/2		30. Name and address of person who co	und 3	05 7	(Туре, е _г	Print) NTL 57	Po	comoKi	-64	MI	0
Sta Registi		MAR 2 8 2	005 37 Refistrat	r's Signature	19	back					

			1 - For State Registrar	State of Maryland / Depa	artment of Health and crtificate of Death	Mental Hygien	2005
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Modeline To	avlor		2. Date of Death Month March 23	Day Year 3. Time of Death 7
	Examir Funeral Director		4a. Facility Name (If not institution, give s 6.53 Wyecombe 5. Social Security Number 6. September 197 - 34 - 4428	way	4b. City, Town, or Location of Dea A I + I - O - C If Under 1 Year If Under 24 Hr Months Days Hours Mir	s. 8. Date of Birth	BAltimore 9 Bithplace (State or Foreign
	death with the Maryland ms 23a or 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD BAH A	nore BAIT	imore		10d. Inside City Limits 1
9800	ours after ref., or Ite Examine	by Funeral	10e. Street and Number 6653 WYE Cambe 6 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	Nas Decedent of Hispanic Origin? (1 Yes, specify Cuban, Mexican, Pue		14. Race - American Indian, Black, White, etc. Specify: Black
d 21215-0036	ges 1 and 2 should be filed within 72 hours t of Health and Mental Hyglene. If item 27 is marked other then "neturel; or other treumatic event, Ire Mudical Ex	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+) (Give life.	dent's Usual Occupation kind of work done during most of w DO NOT use retired HOUSE KEEPE	Ch	Kind of Business/Industry Arles Hickey Lool For Boys
Maryland	lould be Mental I harked o	To Be	COLON G.	white	Shelle	e V. Jone	s white
_	is 1 and 2 sho of Health and item 27 is m other treum		19a. Informant's Name/Relationship (Ty. Kevin Taylor. 20a. Method of Disposition	50N 422M	AIN St. Harley Sc	ulle, PA 1	9438
Baltimore,	permit. Pages Department of I Importent: If ite eny injury or o	×	1 ★ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)		sition (Name of natory or other place) CEMETERY 3-6		Enton - City or Town, State
Ball	permit. Pag Department Importent: eny injury c		21. Signature of Funeral Service License		. Name and Address of Facility	4 Home 911 W	Isabella St. Salis, MD
8760,	rate be executed /Medical Examiner and the burial-transit	I Examiner	Sequentially list conditions, if any, leading to impure cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death)	HyperTensive Ar			Approximate Interval Between Onset and Death Sylbars
.O. Box 687	e death certific the attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Δ_	juires that th n signed by ild be detacl	by	Part II. Other significant conditions con	tributing to death but not resulting in the ur	nderlying cause given in Part I.		use contribute to the cause of death?
Vital Records,		e Completed	25. Was case referred to medical			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ◯ No
of Vi	di S	To B	examiner?	ospital: 1 🔲 Inpatient 2 🗀 ER/Outpatien	Other	ath Check on one Home 5 X Residence	6 ☐Other (Specify)
Division o	ling After fune	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how inju	ury occurred
Divi	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, te)
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my knowledge, death er: On the basis of examination and/or inv and manner stated.	occurred at the time, date and placestigation, in my opinion, death occ	e, and due to the cause(: urred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
)	Totl withi	M	29b. Signature and title of certifier	Deputy	29c. License number		ate signed (Month, Day, Year)
	1 900	/	Name and address of person who con	mpleted cause of death (Item 23a) (Type, Item 23a) (Type,	Print) > 4:11 (7.1.+h.a.	muilla MAO	WIAND 21093
	Sta		31. Date filed (Month, Pay, Year) MAR 2 8 2	32. Reflistrar's Signature	houbs		7

			Please Type or							egible.	
			1- State Registrar	of Maryland / [rtment of H <i>tificate of L</i>		Mental Hy	giene Reg. No.	005	12080
			Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·				2. Date of De	aath		3. Time of Death
	Physici /Medio			wnsend Sr.				Month	Day 7 2 5.	Year 2005	0340 M
	Examir	er	4a. Facility Name (If not institution, give street and no	imber)		4b. City, Town, or	Location of Dea		4c. Co	ounty of Death	
	Francis		5. Social Security Number 6. Sex	7. Age (In yrs. last bin	thday)	If Under 1 Year	SDU 4 If Under 24 Hr	S. R. Dato of Bir	W	iconic	O Contraction
	Funeral Director		219-60-2036 12KM 2 F		Yrs.	Months Days	Hours Mir		iy, Year) 952		lace (State or Foreign try) Vland
	pul		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town							
	Maryla f sho	ō								1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	128e	Director	Maryland Wicomico 10e. Street and Number	Sal	lisb	ury 10f. Zip Code			10a. Citize	n of What Coun	
	or deeth with the Maryland teme 23e or 28e-f show wr mat be notified at	a Di	4348 Snow Hill Rd.			2180	04		USA		.,.
	eme ;	Funeral	11. Marital Status 12. Was De Armed F	edent Ever in U.S.	13. W	as Decedent of Hi Yes, specify Cuba		Specify Yes or No		Race - Americ Black, White,	
9	afte or	by Fu	1 ☐ Never Married 2 ☐ Married 1 🖫 Yes	2 🗌 No		Yes 2 No	Specify:	no moun, otc.)		an eif	
5-0036	72 hours afte "naturel", or I		3 ☐ Widowed 4 ☑ Divorced Year or	Dates: Marines	Decede	ent's Usual Occupa	ation				white
ر د ا	I be filed within 72 ntal Hygiene. ed other then "nat event, the Medic	Completed	(Specify only highest grade completed	1-4or 5+)	(Give k	ind of work done a O NOT use retired,	luring most of we	orking	166. Killu	of Business/Inc	lustry
7	filed with Hygiene other the	Com	Elementary/Secondary (0-12) College —	1-401 34)	Fai	rmer			A	gricult	ure
and	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					me (First, Middle			
Ξ	d Men d Men narke	²	Lee Francis Townsend		Tarker West		Bettye	Waller			
<u> </u>	ormit. Pages 1 and 2 should be partment of Health and Menis inportent: If item 27 Is marked any injury or other treumatic e	(.5)	19a. Informant's Name/Relationship (Type, Print) Lee F. Townsend Sr/fathe:			Address (Street a					
ē,	s 1 an f Heal fem 2 other		20a. Method of Disposition	20b. Place of	Disposi	30 Rollir		WS Rd S	alish	ury MD tion - City or To	21804 wn. State
Ē	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from '4 ☐ Donation — 5 ☐ Other (Specify)	State Wicomi	y, cremi CO I	atory`or other place Memorial	3/2	9/2005		sbury, 1	
Saitim	mit. partm ports y inju		21 Signature of Funeral Service Licensee	Fal	22.	Name and Addres	1				sociation
מ	40 E B D		David H. Dompson	CFSP)(I SHOW I	IIII KQ.	Salish	urv.	onal Ass MD 2180	sociation
	Will Live		23a. Part1. Enter the disease, or comclications that shock, or heart failure. List only one cause on	each line.	not enter	the mode of dying	, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	reuse M	1	Conelyc	n m	toneh	4		Onset and Death
	Examiner		Due to	(or as a consequence of		Attai	2201	Leia 80	. 2*		
li		ler	Sequentially list conditions, if any, leading to immediate Due to	(or as a consequence of	-/-	_0 1 1 0 0	000-0	(0200)			
	e executed ian and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		U						
Ď,	e exe sian al urial-t		resulting in death) Last Due to	(or as a consequence of	of):						
0/00	cate b physic the b	Physician/Medica	d								
YOG	certifi oding Ise as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, ou	tcome of pregnancy					004	Data of dalive	
0	death e atter d for u	iciar	in the past 12 months?	oirth 2 Fetal death		ctopic pregnancy Other (specify)			230	Month	y Day Year
5	at the by the tache	hys	9 ☐ Unknown 9☐ Unkr			500 500					
'n	To the Hospitel or Attending Physicien: The law requires that the death certificate be within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu	þ	Part II. Other significant conditions contributing to c	eath but not resulting in	the und	lerlying cause give	n in Part I.				cause of death?
colos,	w requir been si should	ompleted			71 1	- 'C			/es 2□N		· V-
ב	has ge 2 s	mp	2) Carollel	amy		nr.		24a. Was autop	an 2 sy rmed?	4b. Were autop prior to com death?	sy findings available pletion of cause of
Ital	icien: Th certificate rector, pag	e Co	25. Was case referred to medical					1 ☐ Yes	20 No	1 ☐ Yes	2□ No
	ding Physicien: The la h. After this certificate has funeral director, page 2	0 0	examiner?	Inpatient 2 ☐ ER/Out	patient	3 DOA Other		ath <i>(Check only o</i> Home 5 ☐ Resid		Other (Specify	
5	ding Phys	T:uc	27. Manner of Death 28a. Date	of Injury 28b. Ti		28c. Injury Work	at	28d. Describe h			
5	eath. or: Af the fu	catic	2 Accident investigation	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.,ury		es 2 No				
	or Attenditer death	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	of Injury - At home, far ing, etc. (Specify)	m, stree	t, factory, office		28f. Location (S City or Tox	Street and N vn. State)	umber or Rural	Route Number,
_	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	O	29a. Certifier 1 Certifying Physician: To the	heet of my knowledge	doath	and at the time	- data and stand				
	e Hos 24 hos e Fun letely	Medical	(Check only 2 Medical Examiner: On the b	asis of examination and ner stated.	Vor inve	stigation, in my opi	e, date and place inion, death occi	e, and due to the aurred at the time.	date and pla	d manner as sta ice, and due to	ted. the cause(s)
	within To th comp	Me	29b. Signature and title of certifier			29c. License			29d. Date si	igned (Month, D	ay, Year)
	8. O		1/1/16			DRS	036			25105	
	173		30. Name and address of person who completed cau	e of death (Item 23a) (I	Type, Pr	int) SRN S	HORB	Drive	SA	LISB	ung Ma
•	Stat Registra	te	31. Date filed (Month, Day, Year) MAR 2 8 2005	distrar's Signature	1	and a			*		,
	riegistic			TO JO	140						

Registrar DHMH 17 Rev 1/2001

	4	For State Registrar	State of Ma	•	partment of Heartificate of I			a. No.	12001
		Decedent's Name (First, Middle, Li	ast)				2. Date of Death	/-	3. Time of Death
sician		Denise	Michelle	Talle	S.7		Month March 1	Day Year () 2005	6:30 a.m
edica		4a. Fecility Name (If not institution, gi		Turre.		Location of Death	Haren 1	4c. County of Dea	
miner	r				,				
		45112 Lighth 5. Social Security Number 6.		e (In yrs. last birthda		Point If Under 24 Hrs.	8. Date of Birth	9. Birt	Mary's hplace (State or Foreign
ral			1□M 2∰F	Vrs	Months Days	Hours Min.	(Month, Dey, Y	rear) Co	ountry)
or	-	218-58-1281 Usual Residence of Decedent		52			July 22,	1932 was	nington, DC
	-	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
=	5			_					1 ☐ Yes 2 ∰ No
100	20		Mary's	P:	iney Point		100	g. Citizen of What Co	unto/2
1	5	10e. Street and Number			10f. Zip Code		100	g. Citizen of what Co	ourning s
9	<u>a</u>	45112 Lighth				0674		<u>United St</u>	
90	Completed by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Spe In, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Rece - Ame Black, Whit	
i	2	1 Never Married 2 Married	1 Tes 2	No	1 ☐ Yes 2 █ No	Specify:		Specify: Wh	ito
2	5	3 Widowed 4 Divorced	Year or Dates:					Open, Wil	
400	ted	15. Decedent's I (Specify only highest g	Education	16a. Dec	cedent's Usual Occup	ation	na 16	8b. Kind of Business	Industry
ç	g.	Elementary/Secondary (0-12)	College (1-4or 5	life	. DO NOT use retired	1)			
2	6	12	G0.10g0 (1 101 1	,	Secreta	.rv		Private	Business
		17. Father's Name (First, Middle, Las	st)	· · · · ·		18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
ď) Be	Leonard Craw	ford			-Pa	tricia M	cGowan	
È	6	19a. Informant's Name/Relationship		10h Ma	iling Address (Street				Zin Code)
		Raymond J. Tall	ey, Jr./Hu		12 Lightho position (Name of			OINT, Mary	
		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	□Removal from State	cemetery, ci	rematory or other plac		20	DC. Location - City of	Town, State
		°4 □Donation 5 □Other (Spec		Arlingto	on Nationa	1 3-22	-2005 A	rlington,	Vircinia
		21. Signature of Euneral Service Lic	2000		22. Name and Addres			Funeral 1	
	-	Edward N. Brinsfi	eld. IV	м00052	22955 Holl				20650-02
		23a. Part1. Enter the disease, or co							Approximate Interval Between
ı		shock, or heart failure. List onl	y one cause on each li	ne.		•			Onset and Death
		Immediate Cause (Final disease or condition resulting in death)	_a Obliter	ative Bro	nchiolitis	8			2 Years
		resulting in death)	Due to (or as	a consequence of):					
		Sequentially list conditions,	b. Lung Tr	ansplanta	tion				4 Years
200	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
2	Ē	that initiated events	c Chronic	Obstruct	ive Pulmon	ary Disea	se		10 Years
1	Ĕ	resulting in death) Last	Due to (or as	a consequence of):					
0	dlcai		d						
Ť	ed								
18.8	Ž.	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of de	livery
100	a	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	Ectopic pregnancy	′		Month	Day Year
4	Sic	1 Yes 2 No	4□Pregnant a 9□ Unknown	tunte or death	5 ☐ Other (specify)				
ř	Completed by Physiclan/M				and the second s	and De 11	One Distant	lane use essentitude	the cause of death?
7	٦	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause giv	en in Part I.			
ζ	B						1 🖪 Yes	: 2 □ No 3 □ P	robably 4 Unknov
124	et						24a. Was an	24b. Were a	utopsy findings availab
Į.	티						autopsy	ed? death?	completion of cause of
									2 ∰ No
0	Be	25. Was case referred to medical examiner?	Li conitati		100	26. Place of Death	(Check only one))	
F	2	1 ☐ Yes 2 ♠ No	Hospital: 1 Inpatie			4 🗆 Nursing Hor		ice 6 Other (Spe	cify)
Š	ä	27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time			28d. Describe how	v injury occurred	
	ati	2 Accident investigati	on		M 1 🗆	Yes 2 □No			
100	<u>.</u> 2	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	289. Place of in	ury - At home, farm,	street, factory, office		28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
idnable	=	4 I Homicide	bulldary, et	c. (Specify)			ony or rown,	Oldio)	
-landifination	ertil			of multipopuladae, de	ath occurred at the tir	ne, date and place,	and due to the cau	use(s) and manner a	s stated.
Cortification.		29a Certifier 1 Certifying	Physician: To the best	OI MY KNOWIEGGE, GE		pinion death occurr	ed at the time, dat	e and place, and due	to the cause(s)
		(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	f examination and/or	investigation, in my o	pinon, death occur			
		(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	f examination and/or	investigation, in my o				
		(Check only 2 Medical Ex	aminer: On the basis of	f examination and/or	investigation, in my o			d. Date signed (Mont	
		(Check only 2 Medical Ex	aminer: On the basis of	f examination and/or	investigation, in my o	e number			
	Medical Certif	(Check only 2 Medical Ex	aminer: On the basis of and manner st	of examination and/or ated.	29c. Licens	e number			
		(Check only 2 ☐ Medical Expone) 29b. Signature and title of certifier	aminer: On the basis of and manner st	of examination and/or ated.	29c. Licens D0056 De, Print)	e number	290	d. Date signed (Moni	

Physicia	n l	1. Decedent's Name (First, Middle, Last) Mary Deborah Lydda Mary Deborah Lyddane Trilling		2. Date of Death Month	Day Year
/Medic	al _			March 27	, 2005 11:05 A. ^M
Examin	er	4a. Facility Name (If not institution, give street and number) 5805 Namakagan Road	4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthplane (State or Foreign
Director		577-78-6417 1□M 2△F 51 Yrs.	Months Days Hours Min.	(Month, Day, Y August 2	22,1953 Wash.,DC
and	+	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d, Inside City Limits
Maryl f sho	ō	Md. Montgomery Bethe	sda		1X☐Yes 2☐No
r 28a	ပ္ ြ	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
23a c	ai D	5805 Namakagan Road	20816		USA
filed within 72 hours after death with the Maryland Hygiene, Hysiene, or items 23a or 28a-f show sitt, it e Mysical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I □ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
"natural", or		15. Decedent's Education 16a, Dec	edent's Usual Occupation	16	6b. Kind of Business/Industry
M. n.	plet	(Specify only highest grade completed) (Gi	re kind of work done during most of workii DO NOT use retired)	ng	
ed wil	Completed	<u> </u>	Receptionist		Country Club
be fill bd ott	Be	17. Father's Name (First, Middle, Last) E. Stuart Lyddane	18. Mother's Name		
hould d Mer mark matic	은	and the second s	iling Address (Street and Number or Rura	MayDooli	
nd 2 s lith an 27 is r trau			-		lexandria, Va. 22314
permit. Peges 1 and 2 should be filled within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; any Injury or other traumatic event, it a Micrial Exa		20a. Method of Disposition 20b. Place of Dis	position (Name of ematory or other place) April	Date 20	Oc. Location - City or Town, State
Pege ant: H		'4 □Donation 5 □Other (Specify) Oak Hil	1 Cemetery 2005	<i>V</i>	Washington, D.C.
ermit. eperti nport ny Inj		21. Signature of Seneral Service Licensee	22. Name and Address of Facility De Vo		
0 D = 4 O	-	23a Part. Enter the disease, or complications that caused the death. Do not e	2222 Wisconsin Ave.		
/Medical Examiner and prize pr	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Complications of Due to (or as a consequence of): Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Chronic Alcohol Ab	use	
I the death certific by the attending p ached for use as	by Physician/Med		B⊟Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
w requires that s been signed b should be det	d by P	Part II. Other significant conditions contributing to death but not resulting in the Multiple Injuries	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death? s 2 No 3 Probably 4 Unknown
The law recate has bee page 2 sho	Completed			24a. Was an autopsy perform	prior to completion of cause of
icien: certific ector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death		
Phys r this ral dir	- T	1 Inpatient 2 Envoutpat		me 5 Residen 28d. Describe hov	nce 6 XOther (Specify) At scene
th. ; After	tion	27. Manner of Death 1 Natural 5 Pending 2 Xaccident investigation 28a. Date of Injury Found, Day Year) 3-27-05	of 28c. Injury at Work? AM 1 ☐ Yes 2 【XNo		Fell Down Steps
Atter	ifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)			eet and Number of Rural Route Number. Roa State) 5805 Namakagan Roa
tel or rs efte al Dir ed in	Certification;	Scene	В	ethesada	, Md
To the Hospital or Attending Physician: The law within Z4 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de constant on and/or and manner stated			
To the To the Comp	×	29b. Signature and title of certifier	29c. License number OCME	29	d. Date signed (Month, Day, Year) March 28, 2005
1		Fance Brownall, MD			IMICII 20, 2007
		30. Name and address of person who completed cause of death (Item 23a) (Type			more, Maryland 21201

			For State Registrar	State of Maryl	and / Depa		lealth and I	Mental Hygi	iene No. 0 0 5	12083
ı	Physici		1. Decedent's Name (First, Middle, Last) Suzanne Simone	Thompson				2. Date of Death Month March	Day Year 23, 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Death		4c. County of Death	3.301
	Exa, IIII	Ü	Civista Medi	cal Cente	r	LaP1	ata		Charle	
	Funeral Director		5. Social Security Number 6. Sex 1002-16-2121		yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Oct. 27	O Riet	nplace (State or Foreign unity) Hampshire
	yland 10w		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	e Mar Ba-fat	Funeral Director	MD Charles		LaP1a	ta				1∭XYes 2 ☐ No
	with the	Dire	10e. Street and Number	- D.1		10f. Zip Code	0616	10	og. Citizen of What Co	untry?
	leath ne 23	erai	6850 Hawkin's Ga	TE KU. 12. Was Decedent Ever	in U.S. 13.		0646 Hispanic Origin? (S	pecify Yes or No-	USA 14. Race - Amer	rican Indian.
036	ours after o el', or iter Examiner	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2 1 No If Yes, Give Year or Dates:		f Yes, specify Cub 1 □ Yes 2 X □ No	dispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Black, White Specify: Whi	e, etc.
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. And the than "natural", or iteme 23a or 28a-f ahow ovent, the Madical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of wor d)	king	16b. Kind of Business/I	
CA	illed w Hygier ther th		12 17. Father's Name (First, Middle, Last)			Homemake	,	ne (First, Middle, N	Own ho	ome
and	ld be f ental I ked o	To Be	Damase Paquin					Trapanie		
Maryland	3.2 should be filed within h and Mental Hygiene. 7 is marked other than " freumatic event, tre Mac	-	19a. Informant's Name/Relationship (Type	ре, Print)	19b. Mailir	ng Address (Street			City or Town, State, Z	ip Code)
Σ	and 2 ealth m 27 i ner tre		Daniel Mattingly /		6850	Hawkin's	Gate Rd.		ta, MD. 206	
Baltimore,	permit. Pages I and 2 should be Department of Health and Mental importent: If item 27 is marked of any injury or other treumatic evonce.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	onioval nom State		sition (Name of natory or other pla ion Ceme			20c. Location - City or $^\circ$	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service License	Powel	16	2. Name and Address NW C	ess of Facility Be rain Hwy.	all Funer Bowie		.5
	Physician /Medical Examiner Medical Examiner Medical Examiner Medical Medica	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):	ıîΑ			8	Interval Between Onsel and Death WWKS
68760,	tificate be e g physiciar as the buris								L	
P.O. Box	The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pre 1□Live birth 2□I 4□Pregnant at time 9□Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deli	very Day Year
rds, P	quires that an signed b	by	Part II. Other significant conditions cor					7-V	acco use contribute to s 2 ☐ No 3 ☐ Pro	
of Vital Records,	: The law requ cate has been . page 2 shoul	Completed	CARDIAC A	RRYTHM	IA			24a. Was an autopsy perform	ned? prior to c	topsy findings available ompletion of cause of
<u> </u>	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	0.5550	- Ott		th (Check only one		
on of	ing After une		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	28c. Inju Wo	ry at rk? Yes 2 ☐ No	ome 5 ☐ Resider 28d. Describe hov	nce 6 Other (Spec w injury occurred	ify)
Division	el or Attending s after death. il Director: After od in by the funel	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru , State)	ral Route Number,
	To the Hospitel within 24 hours a To the Funeral C completely filled	edicai (29a. Certifier (Check only one)	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, death mination and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier	0 -1.1		29c. Licens			d. Date signed (Month	
	(10)	/	30. Name and address on erson who co	mpleted cause of death	(Item 23a) (Type		4436	1	MARCH 2	3 2005
a	Sta	to.	Ashvinkumar J F		102 Pa		on Cour	t Ste 10	02 Waldor	f, MD 206
\$ C	Registr		MAR 2 4 2005	men let	Lucks					

			1 - For State Registrar	State of M	Maryland		artment of H		and Me	-	jiene L Nog. No.	105	12084
	Physici /Medio	al	Decedent's Name (First, Middle William A. Facility Name (If not institution	Urner		lbott	4b. City, Town, or	Location	М	Date of Dea Month arch	31 ^{Day}	2005 unty of Death	3. Time of Death 4:53 a. M
	Examin Funeral	er	Kline Hospice 5. Social Security Number	House	Age (In yrs. la	ast birthday)	Mt. Ai If Under 1 Year Months Days		24 Hrs. 8.	Date of Birth (Month, Day	Fr	ederic	
	Director		220-01-5648 Usual Residence of Decedent 10a. State 10b. County	1 ∑ M 2□F	83	Yrs.		Hours	Jı	ine 8,	1921	Mar	y Land 10d. Inside City Limits
	ith the Maryle or 28a-f sho	Olrector	Maryland Fred	lerick		ersvi	10f. Zip Code				_	of What Cou	tv Yes 2 □ No
36	urs after death w	by Funeral Director	17 Harp Place 11. Marital Status 1 Never Married 2X Marriad 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 XYes 2(If Yes, Give Year or Date	s? ⊒No		21773 Was Decedent of Hi f Yes, specify Cuba 1□ Yes 2∏ No	ispanic Origin, Mexican Specify:	gin? (Specif i, Puerto Rid	y Yes or No- can, etc.)		Race - Ameri Black, White	
21215-0036	od within 72 hou glene. er than "nature , the Medical	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12) 1.2	t's Education		16a. Deced (Give life.	dent's Usual Occupa kind of work done o DO NOT use retired istrative	during most ()				of Business/Ir	
Maryland	nould be file I Mental Hy narked oth natic event	To Be (17. Father's Name (First, Middle, John William	Talbott				Alm	ira	Koonta	z Da	avis	
altimore, Mai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Mudical Exist, it is mast be notified at ance.		19a. Informant's Name/Relations Hazel C. Talbot 20a. Method of Disposition 1 XBurial 2 □ Cremation 4 □ Donation 5 □ Other (S	t / wife 3 □Removal from Sta	te C6	17 Ha ace of Dispo	rp Place, sition (Name of natory or other place. .Methodis	, P. (115,	Myers	sville	, MD 21773
Baltii	permit. F Departm Importar any injure		21. Signature of Funeral Service				Ricketts	ss of Facilit	ty		504 Ma	ain Str	
	Pnysician /Medical Examiner		23a. Part1. Enfer the disease of shock, or head failure. List Immediate Cause (Final disease or condition resulting in death)	a Due to (or	sed the death ine. 	naj	er the mode of dying Fhrus		cardiac or r	espiratory ar	rest,	5	Approximate Interval Between Onset and Death
8760,	death certificate be executed to attending physician and ad for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Lisable of Injury that initiated events resulting in death) Last	C	as a consequ							11.00	
P.O. Box 6	death certif e attending od for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 ☐ Fetal t at time of de	death 3[Ectopic pregnancy Other (specify)				230	I. Date of delive Month	very Day Year
	The law requires that the de ate has been signed by the a bage 2 should be detached f	by	Part II. Other significant condition	ons contributing to deat	n but not resu	ulting in the u	ndertying cause give	en in Part I.		23e. Did to			the cause of death?
Vital Records,	(0	Completed								24a. Was autop perfor 1 🗆 Yes	sy	24b. Were aut prior to codeath?	opsy findings available ompletion of cause of 2 No
o	g Physician: The string of this certificate eral director, page	n: To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inp.	atient 2 🗆 I	28b. Time o		er: 4 🗆 Nu	ırsing Home	Check only of 5 ☐ Resided. Describe h	lence	ther (Special	HOSPICE
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	ertification:	1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could 4 Homicide determ	gation not be 28e. Place of	Day Year) Injury - At ho etc. (Specify	Injury me, farm, str		k? Yes 2□		f. Location (S City or Tow		lumber or Rui	ral Route Number,
	the Hospital hin 24 hours a the Funeral upletely filled	Medical C	29a. Certifier 12 Certifyir (Check only one) 1 Medical	ng Physician: To the be Examiner: On the basi and manner	s of examinat	wledge, deat ion and/or in	h occurred at the tim vestigation, in my op	ne, date an pinion, dea	d place, and th occurred	d due to the o	cause(s) and pla	d manner as ace, and due	stated. to the cause(s)
)	To the by within 2.	Z	29b. Signature and title of certifie	itin Pra	rre			e number	, %9			3/31/c	,
	C.	ate	30. Name and address of person Austin Pearre 31. Date filed (Month, Day, Year,	, M.D., 300		9th S		ederi	.ck, M	arylan	d 217	01	
	Regist	ate rar	82 AVD Mr	2005	es &	Los	all I						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1 1 5 12005 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Jacqueline Thompson APRIL 02, 2005 1345 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Memorial Hospital ALLEGANY CUMBERLAND Months Days Hours Min. Jan 22 5. Social Security Number 6 Sex 7. Age (In vrs. last hirthday) Birthplace (State or Foreign Country) **Funeral** 1930 1 □ M 20 F 75 Director 214-28-6831 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location "natural", or items 23s or 28a-f show idical Examination multifled at 10d. Inside City Limits MD Allegany Cresaptown Director 1 Yes No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23s any injury or other traumatic event, II is Maritman in a 23s. 12829 Knobley View Ave 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2√2 No Specify: þ Specify: White 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Edward Barnett Nina (Wright) Barnett Suder ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12829 Knobley View Ave Cresaptown, MD 21502 Stephen Thompson Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillrest Mem Park Apr 5 2005 Cumberland, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral Service PA 1302 National Hwy., LaVale, MD 21502 23a. Part1. Enter the disease or complications that caused limited death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** gendeal 2 de /Medical Due to (or as a consequence of): **Examiner** ach Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exan iner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical (in IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2.☐ No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 110 1 ☐ Yes 2 ☐ No 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) si 4, 00017565 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LaVale 11501 Bollino MD 922 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

7 2005

State of Maryland / Department of Health and Mental Hygiene

				State of h	viai yiai	•			Death	Wentai ny	Reg. No.		
	0		1. Decedent's Name (First, Middle, L	ast)						2. Date of De		U Vear	3. Time of Deeth
	Physici /Medic	al		ardner	Wal	ls Jr				March Location of Deat)5	4.14 pm
	Examin	er	4e Fecility Neme (If not institution, g 1436 Mt. Hermon		or)			4	b. City, Town, or Salisbu			ity of Deeth	
	Funeral		Social Security Number 6.		Age (In yrs.	lest birthday)		er 1 Year	If Under 24 Hrs	8. Date of Bir			plece (Stete or Foreign ntry)
	Director		217-52-0219	1 M 2 F	51	Yrs.	Month	Deys	Hours Min	9/7/19	53		yland
	pue *	-	Usuel Residence of Decedent 10e. Stete 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	Maryler show	ō	Maryland Wicomi	CO	S	alisbu	rtz						1⊠Yes 2□No
	or 28e-f	8	10e. Street end Number			alibba		ip Code			10g. Citizen o	f Whet Cou	ntry?
	23 c	Funeral Director	1436 Mt. Hermon	Rd.				2180	4		USA		
	er de	E L	11. Merital Status	12. Was Deceder Armed Force	s?	I,S. 13. \	Vas Dec f Yes, sp	edent of H ecify Cuba	ispanic Origin? (: in, Mexican, Puei	Specify Yes or No to Rican, etc.))- 14. Ra	ace - Ameri lack, White,	
20	is eff	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Date:			I □ Yes	2 ∑ No	Specify:		Spec	ify: W	nite
9-6	within 72 hours efter deeth with the Marylend ene. than "natural", or items 23e or 28e-f show the Medical Examiner must be indiffed at	<u>8</u>	15. Decedent's	Education		16e. Deced	ient's Us	uel Occup	ation	4.1	16b. Kind of	Business/In	ndustry
21	ithin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-40	r 5+)	life. I	DO NOT	use retired	during most of wo	orking			
121	e filed with el Hygiene. other than	S -	12. 17. Fether's Neme (First, Middle, Las			Con	ntra	ctor	40 Man ad Ma	(Fina 88114)		nstru	ction
Maryland 21215-0020	nd 2 should be filed lith and Mentel Hygin 27 is marked other r traumatic event,	Be C	James Gardner Wa	•						me (First, Middle		•	
ary	should Me mark	ဥ	19a. Informant's Name/Relationship			19b. Mailir	g Addre	ss (Street		la Lee Numb			p Code)
	and 2 alth e 27 is or tree		Dottie Walls/wi	fe		143	36 M	. He	rmon Rd.	. Salish	ourv M	D 218	04
Baltimore,	ges 1 and to the strain or other		20a. Method of Disposition 1 St Burial 2 ☐ Cremation 3	□Removal from Sta	20b. F	Place of Dispo	sition (N	ame of other plac	Θ)	, Salish Date 2/29/05	20c. Location	n - City or To	own, State
ij	Eant: Peg		4 Donation 5 Other (Spec	eify)	WIG								
Bal	permit. Peg Depertment Important: if any injury o		21. Signature of Funeral Service Lig	ensee			IOII	and Addres Way	Funeral	Home Pro	ofessio	nal A	ssociation
e.			23a. Part1. Enter the disease, or co- shock, or heart failure. List on	mplications that caus	ed the deat	th. Do not ent	er the mo	de of dyin	g, such as cardia	c or respiratory a	rrest,	<u>D 2100</u>	Approximate Interval Between
	Physician			y one cause of caus								1	Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a METI	AST	ATIC	L	420	CAN	VEER			3/2 years
17	Pi to s SAE	e	,		Due to (d	or as a consec	uence o):				1	0
	cuted	Examiner	Sequentially list conditions.	b	Due to (or as e conseq	uence of):					
,00	requires thet the death certificete be executed een signed by the ettending physicien end hould be deteched for use as the buriel-trensit	EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
68760,	physic the b	edicai	that initiated events resulting in death) Last	G	Due to (d	or as a conseq	uence of):			-		
	ding b	-		d								i	
Box	death cer e ettendin d for use	Iclar	Part II. Other significant conditions	contributing to death	but not rec	culting in the u	ndarkina	cauca che	on in Part I	22h Did	tabecca usa c	ontributo 1	to the causa of death?
P.0	by the enterprise the checked	Physician/	Tartii. Other arginican conditions	contributing to death	Dut not res	and the di	idenying	Cause giv	en in raiti.		Yes 2 No		
	es thet igned be det	þ				-							
ecords,	v require been si should	Completed								24a. Was perfo	an autopsy ormed?	av	Vere autopsy findings vailable prior to completion of cause
Rec	hes ye 2	d H										of	f death?
a	Pa es		25. Was case referred to medical							10		11	☐ Yes 2☐ No
>	Physician: this certific rel director,	o Be	examiner?	Hospital:	itient 2	ER/Outpatier	t 3 🗆 🛭	OA Oth	or:	eath (Check only) Home 5 Resi		ther (Speci	ifv)
ō		Ä:T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28e. Date of Ir (Month, L	ijury De <i>y Year)</i>	28b. Time of		28c. Injur			how injury occ		
Sio		catic	2 Accident investigeti 3 Suicide 6 Could not	on		, , ,	М		Yes 2 □ No				
Division of Vital	or Att	ŧ	4 Homicide determine	A 286. Piece of I	Injury - At h etc. <i>(Specil</i>	ome, ferm, str fy)	eet, facto	ry, office		28f. Location (City or To		nber or Run	al Route Number,
	To the Hospital or Attent within 24 hours efter deet To the Funeral Director: completely filled in by the	edical Certification:	29a. Certifier 1 Certifying F	hysician: To the bes	st of my kno	wledge, death	occurre	d at the tin	ne, date and place	e, and due to the	cause(s) and	manner as	stated.
	n 24 h	edic		miner: On the basis end manner	of examina								
	Withii Vithii Comp	Z	29b. Signature end title of certifier	-46	4		2	9c. Licens			29d. Date sign	ned (Month,	Day, Yeer)
	C	1	Kalent	2. Chin	Im.	m		000	0567	76	3/	25/6	25
	15	7	30. Name end address of person who	-		m 23e) (Type,	Print)	= /	1. 10001	1 0	(11.10), 01,	MD 21801
4	Sta	0	31. Dete filed (Month, Day, Year)	32. F	strar's Signa	ature	75	L. 6	MICICOL	- >j.	>HL1313	UK/	TH 21801
180	Pogietr		MAR 2 R	2005		H. A	and a					-	

			For State Registrar	State of M	_	partment of Fertificate of		and Mental	Hygien	211115	12087
			1. Decedent's Name (First, Middle,					2. Date	of Death		3. Time of Death
	Physici: /Medic		THOMAS	WALSH		1		03	30	2005	
	Examin	er	4a. Facility Name (If not institution,			4b. City, Town, o		of Death		c. County of Deal	
	Funeral			S. Sex 7. Ag	ge (In yrs. last birthd	ay) If Under 1 Year	If Under		of Birth th, Day, Yea		thplace (State or Foreign
D.	Director		002269651	1 X M 2□F	69 Yrs	Months Days	Hours	Min. (Mon 5-30	-1935		nington,D.C.
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
	Maryl is d	tor	VA Prince	William	Gainesvi	11e					1 ☐ Yes 2 X No
	th the	lirec	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	ountry?
	23e (raic	6901 Saddle Ru			20155				.A.	
	within 72 hours efter deeth with the Maryland ane. then "netural", or Items 23e or 28e-f show the Modral Examiner must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 Marrie	12. Was Decedent Armed Forces? d 1 ☐ Yes 2 🔼	Ever in U.S.	 Was Decedent of I If Yes, specify Cub 	Hispanic Ori an, Mexicar	gin? (Specify Yes n, Puerto Rican, e	or No- tc.)	14. Race - Ame Black, Whit	
920	urs eft	<u>م</u>	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗶 No	Specify:			Specify: V	Vhite
21215-0036	thin 72 ho e. en "netur Modical I	Completed	15. Decedent's		(G	ecedent's Usual Occupione kind of work done	during mos	t of working	16b.	Kind of Business	/Industry
121	d within piene. r then "	mpi	Elementary/Secondary (0-12)	College (1-4or	5+) lif	e. DO NOT use retire inistrativ	ed)		For	od & Dru	o Admin
d 2	Hygi Hygi ther ant, I		17. Father's Name (First, Middle, L.		Adii	HIITSLIALI	T .	er's Name (First, I			g Admin.
ılan		To Be	J. Herbert Wal	sh			Li11	ian M. B	arry		
Maryland	2 sh and Is m		19a. Informant's Name/Relationshi		4.	ailing Address (Street			-		
	s 1 and 3 if Health Item 27 other tr		Eleanor S. Wal	sh/Spouse		1 Saddle I		y Gaines	-	VA 2015. Location - City or	
nor	of the		1 X Burial 2 ☐ Cremation : '4 ☐ Donation 5 ☐ Other (Spe			isposition (Name of crematory or other pla 111 Memory					Virginia
Baltimore,	permit. Pag Department Importent: I any Injury o	1	21. Signature of Funeral Service L		Deonewa	22. Name and Addre			TICI	uoouo,	ATIGINIA
Ö	P P P P P P P P P P P P P P P P P P P	1 55	> Trans	Wolden		Lee Funera	al Hom	ie, 8521	Sud1ey	Rd. Ma	nassas,VA
г			23a. Part1. Enter the disease, or of shock, or heart failure. List of	nly one cause on each I	line.			cardiac or respira	tory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a		ARY ARR	EST				
	Examiner		, , , , , , , , , , , , , , , , , , ,		s a consequence of):						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	U	s a consequence of):						
	scuted ind transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	0	_					
60,	be executed sicien and burial-transit	icai Ex	resolving in dealin) cast	Due to (or as	s a consequence of):						
68760,	<u>w</u> 5 0			d	-						
Вох	leath certifica attending phi d for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Petal death	3 ☐Ectopic pregnanc	cy			23d. Date of de	livery Day Year
	at the dea by the att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of death	5 Other (specify)				MOTO	Day rear
P.O.	res that the igned by be detact		Part II. Other significant condition	s contributing to death I	but not resulting in th	ne underlying cause gr	ven in Part I	. 236	. Did tobacco	use contribute to	o the cause of death?
rds	quires in sign uld be	ed by	DEMENTIA						1 🗆 Yes	2 √√ 0 3□P	robably 4 Unknown
Records,	ie law requ has been je 2 shoul	Completed	CHRONIC RE	NAL FAILU	RE			24a	. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
E R	: The cate ha	Соп						1 🗆	yes 8/21	death?	2 2 2 2 2 3 2 3 3 3 3 3 3 3 3 3 3
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				e of Death <i>(Check</i> ursing Home 5		A CO.	- 6.1
of	y Phys ar this aral di	n: To	1 ☐ Yes ♥ Z No 27. Manner of Death	28a. Date of Inj (Month, D		e of 28c. Inju				jury occurred	эспу)
ion	ath. or: After t	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investig	ation	ay Year) Inju		Yes 2	No			
Division	or Attendated after death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 286. Place of it	njury - At home, farm atc. <i>(Specify)</i>	, street, factory, office			ation (Street or Town, Sta		ural Route Number,
	pitel ours a pours a p		29a. Certifier 15 Certifying	Physician: To the bes	t of my knowledge o	leath occurred at the t	ime, date ar	nd place, and due	to the cause	(s) and manner a	s stated
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Medicai		xaminer: On the basis and manner s	of examination and/o						
	To the To the Comp	ž	29b. Signature and title of certifier				se number	- 6		ate signed (Mon	_
			Man				06191	5	0	3/31/05	
(0)		30. Name and address of person v				ERSPI	RING 1	4D 2	0902	
	Sta		31. Date filed (Month, Day, Year)		trar's Signature	1				***	
	Regist	rar	APR 0 8	ZUU5	w to	men					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 16 **Physician** Month 3 2005 Frances Marv Wygonik 5:30 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death St. Mary's Nursing Center Leonardtown
Inder 1 Year | If Under 24 Hrs. Mary's If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2\ F Yrs. Director 93 167-52-9639 Aug. 12, 1911 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show The Medical Examiner must be notified at Director 1 ☐ Yes 2 No St. Mary's Leonardtown Marvland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or itams 23a 21585 Peabody Street 20650 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Yes Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: à Specify: Widowed 4 □ Divorced "naturai', White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. other then " Elementary/Secondary (0-12) College (1-4or 5+) 4 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: if Item 27 is marked othany Injury or other traumatic event Be ပ္ Paul Stapincki Josephine Buczek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Runco / Daughter 22424 Armstrong Drive, Leonardtown, Maryland 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cr. 3-18-2005 Charlotte Hall, MD 21. Signature of Funeral Service Reprise

Edward N. Brinsfield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 P.O. Box 279 Leonardtown, Maryland 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a co Examiner Sequentially list conditions, I any, leading to minediate cause. Enter Underlying Cause (Disease or injury Оцы то (от яв а попявация Examiner burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien Box 68760 Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) P.O. | the ۾ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 10 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 Homicide 29a. Certifier 1 D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) e of death (Item 23a) (Type, Print) 30. Name and address of person who completed c Jarboe, M.D 23045 Three Notch Road Hollywood, Maryland 20636 James P. 31. Date filed (Month, Day, Year) MAR 28 State Registra

			State of Maryland / Department of Health and Mental Hygiene
		•	1 - State Registrar Certificate of Death Reg. No. 2005 2089
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Year
	/Medic	al	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Examir	ier"	4a. Fecility Name (If not institution, give street and number) 4b. City. Town of Location of Death 4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
н	Director		219-70-8708 45 Yrs. Jan, 30,1960 Maryland
•	land DW		Usual Residence of Decedent // 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
$\overline{}$	Mary I sho	to	MD. Anne Arundel Severn
7	or 288)irec	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
Q	s 23a	by Funeral Director	8311 Candlewick Court 2/144 USA
Ü	ter de	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
036	ral', o	by	3 Wildowed 4 Divorced If Yes, Give Year or Dates: 1979
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-f show ant, the Medical Examinational be inclified at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
121	within ene. than	dwc	Elementary/Secondary (0-12) College (1-40r5+) 2 Electronics Technician Electronics
	other vent,	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
ylar	should be filled with nd Mental Hygiene. marked other than imatic event, Len	ToE	Calvin A. Wright Elois Jones
Maryland	12 sho		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 11 4 4
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination in the notified at ance.		Mary Ross Wright 831/Cawdlewick Court-Severn Maryland 20a. Method of Disposition Date 20c. Location - City or Town, State
altimore,	Pages nent of int: If it		1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 14 Donation 5 Other (Specify) Completely, crematory or other place) 3 / 26 / 05 Cambidation May Land
alti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 14en Ry Fune Real Home, P. A.
8	8 3 5 8 8		Tanelle C. Servy 510 Washington St. Cambridge, MD. 21613
			23a. Rant T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Drewwon(a)
	Examiner		Due to (dr as a consequence of): GNOXIC ENCEPHALOPATHY
	= . c	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.
	and -trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):
760,	es that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	calE	d d
68	tificate g phys as the		
Вох	th cert tendin r use	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
E	ne dea the at hed fo	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown
۵.	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
rds	w requires been sigr should be	ed by	Congestive heartailure 10 Yes 20 No 30 Probably 4 OUnknown
Records,	law reas bee	Completed	24a. Was an autopsy findings available prior to completion of cause of
E B		Com	performed? death? 1 Yes 2 No 1 Yes 2 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? Hospital: Check only one C
of	Phys er this eral di	 	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
ion	Attending F r death. ector: After by the funera	atio	2 Accident investigation M 1 Yes 2 No
Division	pr Atter ter de irecto n by th	rtific	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	purs al	i Ce	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To th To th	W	29b. Signature and little of certifier 29d. Date signed (Month, Day, Year)
			1 (4 x 10) 00075170 Thank 20,2005
			290. Signature and little of certifier (Le MD) DOY3742 March 20, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Bright, Smile 280 Balt, more, MD 21201 Brian Everle MD 419W. Reduced St, Smile 280 Balt, more, MD 21201
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Regist	rar	MAY 23 2003 COULD STAND

			1 - For Stete Registrar	ate of Maryland / D	Departm <i>Certific</i>	nent of He	ealth and N Death		giene? (005	120	90
	0		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of	Death
	Physici		Richard Newton Wares	5				Month March	Day 200	Year 05	2:16	рм
	/Medic Examin		4a. Facility Name (If not institution, give street	and number)	4b.	City, Town, or I	ocation of Death			nty of Death	2.10	
	LAdillii	Ç.	Holy Cross Hospital	1		Silver	Spring		Me	ontgom	erv	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt		Inder 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birtho	lace (State o	r Foreian
	Director		442-40-6431 IEM	^{2□ F} 64 `	Yrs. Mor	nths Days	Hours Min.	(Month, Da) Sept. 2	v, Yea <i>r)</i> 28 - 194	Cour	ahoma	
			Usuel Residence of Decedent					осре. 2	.0, 134	OKIC	monia	
	/land		10a. State 10b. County	10c. City, Town	or Location	1				1	0d. Inside Cit	ty Limits
	Man,	ō	Maryland Montgome:	rv Sil	ver S	orina					1 🗌 Yes	2 X No
	286 286	Director	10e. Street and Number	511		f. Zip Code		T	10g. Citizen o	of What Cour	itry?	
	with ta or		9802 Lorain Avenue	a		2090	1			USA		
	hours after death with the Maryland turel; or Items 23e or 28e-1 show at Evir, the most be modified at	Funeral		as Decedent Ever in U.S.	13 Was I		panic Origin? (Sp	ecify Ves or No-	14 R	ace - Americ	an Indian	
	lar d	'n.	A	med Forces?	If Yes	specify Cuban	, Mexican, Puerto	Rican, etc.)		lack, White,		
ဗ္ဗ	'or	by F	If	Yes, Give ear or Dates:	1 □ Y	es 2. No	Specify:		Spec	city: Wh	ite	
21215-0036	hour	ğ			Decedentia	Usual Occupat	ion		10h Kind -4	D in a day		
Ċ	"na	Completed	15. Decedent's Education (Specify only highest grade con		(Give kind)		iring most of work	ding	160. KING OI	Business/Inc	austry	
7	with sne. then	E	Elementary/Secondary (0-12)	ollege (1-4or 5+)								
	filed within 72 Hygiene. Hyer then "na'		17. Father's Name (First, Middle, Last)	5+	Engi		18. Mother's Nam	o /First Middle		d Stat	es Gove	ernment
Ĕ	9 m 9 5	Be								атө)		
<u>Ş</u>	ould Men Marke	2	George Wares				Dezzie Mar					
Maryland	ss 1 and 2 should b of Health and Ment Item 27 is marked other treumatics	10	19a. Informant's Name/Relationship (Type, P				nd Number or Rui				,	
	and ealth n 27		John Wares/ Son		1 707 707 7		Avenue,		, Georg	gia 30	606	
e C	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove	20b. Place of cemeter	Disposition y, cremator	(Name of or other place)		Date h 24,	20c. Location	n - City or To	wn, State	
Ĕ	Page III F		' 4 □ Donation 5 □ Other (Specify)	Metropo	olitan	Cremator	v ;	05	Alevar	ndria,	Virai	nia
altimore,	permit. Pages Department of h Importent: If Ite any injury or of		21. Signature of Funeral Service Licensee	0	22. Nan	e and Address	o(Facility Collins				VILGI	.111.0
m	Per		Valle Etome	the state of the s	500	Univer:	sity Blv	d. W.,	Silver	Sprin	a. MD	20901
			23a. Part1. Enter the disease, or complication	ns that caused the death. Do n							Approximate	9
	Late Til.	11	shock, or heart failure. List only one call Immediate Cause (Final	use on each line.							Interval Bety Onset and D	veen Jeath
	Physician /Medical		disease or condition resulting in death)	Acute Cerebral		ılar Ac	cident					
	Examiner			Due to (or as a consequence of								
		ų.	Sequentially list conditions. b.	Acute Myocardia		farction	n					
	sit	iner	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events c	Luia to (or da a consequenco o	ory:							
	ecut and tran	Examin	that initiated events c	D /	- ()			-				
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8760	cate be executed physician and the burial-transit	dicai	d									
9		Ψ	IF FEMALE:									
ВОХ	death certifi e attending id for use as	clan/M	23b. Was decedent pregnant 23c. If	yes, outcome of pregnancy ☐Live birth 2 ☐ Fetal death	3 TEcto	oic pregnancy				Date of delive	,	
-	deal e att	icie	1 Vec 2 No	Pregnant at time of death		or (specify)			\ \ \ \	Month	Day Y	'ear
Ö	at the de by the a tached t	Physi	9 □ Unknown 9	Unknown								
J.	De ab	by P	Part II. Dther significant conditions contribu	ting to death but not resulting in	the underly	ing cause giver	in Part I.	23e. Did to	bacco use co	ontribute to th	e cause of de	eath?
ecords,	w requires to been signer should be		_					1 DXCY	es 2□No	3 🗌 Prob	ably 4 □U	inknown
<u> </u>	A rec	Completed						24a. Was	24h	o. Were autor	nev findinge o	available
Xe E	e lav has	фш						autop perfor	sy	prior to cor death?	npletion of ca	use of
	(0 (7	ပိ							2 X No	1 🗆 Yes	2 🗆 No	
Vital	Physician: The law this certificate has braid director, page 2 s	Be	25. Was case referred to medical examiner?				26. Place of Deat					
0	physi this c	2	1 ☐ Yes 2 ☐xNo Hospit	al: 1∑ Inpatient 2 ☐ ER/Out	tpatient 3	DOA Other	4 🗌 Nursing Ho	ome 5 🗆 Resid	ence 6 🗆 O	ther (Specify	<i>'</i>)	
	ding Ph h. After th funeral	:uc	27. Manner of Death 1 Natural 5 Pending	ta. Date of Injury 28b. T (Month, Day Year) Ir	rime of	28c. Injury a Work?	at	28d. Describe h	ow injury occi	urred		
<u></u>	ath.	atic	2 Accident investigation		М	1 🗆 Y	es 2 No					
Division	al or Attendii after death. I Director: A d in by the fu	ific	3 Suicide 6 Could not be determined 28	te. Place of Injury - At home, far building, etc. (Specify)	rm, street, fa	actory, office		28f. Location (S City or Tow	treet and Nun	mber or Rura	Route Numb	oer,
	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	Certification:	1 110.110.00	ballaling, etc. (Specify)				Only of Ton	ri, olaloj			1
	e Hospitel or 24 hours afte e Funerel Dii letely filled in		29a. Certifier 1 Certifying Physicien	1: To the best of my knowledge	, death occi	rred at the time	, date and place,	and due to the	ause(s) and r	manner as st	ated.	
	24 He Fu	edicai	(Check only 2 Medical Exeminer: (one)	On the basis of examination and and manner stated.	d/or investig	ation, in my opi	nion, death occur	red at the time, o	late and place	e, and due to	the cause(s)	
	To the twithin 24 To the F	Me	29b. Signature and title of pertifier			29c. License	number		29d. Date sign	ned (Month, I	Day, Year)	
			ILLETTA D	00		D625	520		March	23, 20	005	
	60		30. Name and address of person who comple	ted cause of death (from 22a) (Type Print					•		
							1 ** C ** C **	ing Mr (0030			
		•	Maria Arbela, M.D. 31. Date filed (Month, Day, Year)	1500 Forest G			iver spr	rng, MD 2	COATO			
	Sta Registr		MAR 2 4 2005	37 Registrar's Signature	CHORACI							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1. Decedent's Name (First, Middle, Li James Arthur Wes							2. Date of De Month March	Day	2005	3. Time of Death
dical niner		4a. Facility Name (If not institution, gi		er)		4b. City, Tow Lusby	wn, or Location	of Death	TIGE CII	4c.	County of Death alvert	
ai or		5. Social Security Number 6. 333–70–6894	Sex 7 M 2□F	Age (In yrs.	last birthday) Yrs.	If Under 1 Y Months Da	Year If Unde Days Hours	Min.	8. Date of Bi (Month, Di July 2	ay, Year)	9. Birth Co. 111i	nplace (State or Fore intry) .nois
tor		Usual Residence of Decedent 10a. State 10b. County Maryland Calvert		10c. Cit	y, Town or Lo	ocation						10d. Inside City Lim
Funeral Director	3	10e. Street and Number				10f. Zip Co				•	izen of What Cou	,
rall	8	935 Chart Court	12. Was Decede	net Ever in II	C 12	20657 Was Decedent		riain? (Sn	nacify Vos or N		ted Stat	
À	2	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Force 1 Tyes Zi If Yes, Give Year or Date	ps? □No		If Yes, specify	Cuban, Mexica	an, Puerto	Rican, etc.)	0-	Black, White	
Completed	nanaidii	15. Decedent's 8 (Specify only highest g		or 5+)	(Give	edent's Usual O e kind of work d DO NOT use re	Occupation done during mo retired)	ost of work	sing		ind of Business/l	
		12th 17. Father's Name (First, Middle, Las			Labo	rer	18 Moth	her's Name	e (First, Middle		dscaping	<u> </u>
Be	5	Charles Elvin We							France			
မှ	=	19a. Informant's Name/Relationship			19b. Maili	ing Address (St					or Town, State, Z	ip Code)
once. To Be Completed by Funeral Director		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	cify)	Met	tropol:		emator	ility Rau	ısch Fu	neral	•	Virgini P.A. 440 20676
al		23a. Pant. Enter file disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a Diphen	th line.	th. Do not en		of dying, such a					Approximate Interval Between
er examiner	Examil	shock, or heart failure. List only Immediate Cause (Final disease or condition	a. Diphen Due to (or b. Due to (or	h line. hydrai	nine in quence of):	nter the mode of	of dying, such a					Approximate Interval Between
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To Be Completed by Physician/Medical Examiner	Certification; to be completed by Physician/medical Examin	shock, or heart failure. List only mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 2 Accident 3 X suicide 6 Could not determine	a. Diphen Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outcon 1 Live birth 4 Pregnan 9 Unknow contributing to deat Hospital: 1 Inp 28a. Date of Found 1.0 1 De 28e. Place of building Home Physician: To the be	mas a consequence of pregnation as a consequence of pregnation as a consequence of pregnation as a consequence of pregnation at time of community of the consequence	mine in quence of): quence of)	DEctopic pregric Other (specific underlying cause underly	nancy se given in Part 26. Plac Other: 4 N. Injury at Work? 1 Yes 2 [t I. ce of Deat Nursing Ho XNo S and place, eath occur	23e. Did 1 24a. Wa auth 1 Yes th (Check only ome 5 Res 28d. Describe Subject 28f. Location City or 7c Lusby, and due to the	tobacco u Yes 2 s an opsy ormed? 2 No one) sidence in me (Street an own, State MD) MD e cause(s) , date and	23d. Date of deliment of the month of the mo	Approximate Interval Between Onset and Death Death Onset and Death Death Onset and Death

State of Maryland / Department of Health and Mental Hygien 2 0 5 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** David Anthony Mayeth 1²8^y 2005 12:40 р м Walters /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton, Marylaria

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Min. | Month, Day,
June 14 Southern Maryland Hospital Center Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**√**M 2□F 40 New York 220 90 5369 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at MD Prince George's Suitland 1 XYes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4662 LaMar Avenue 20746 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 🏖 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺ No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Private Industry 11 permit. Pages 1 and 2 should be filled Department of Health and Mental Hyg Important: If itam 27 is marked othar any injury or other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clifton Walters Rosetta Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janine Heard/sister 4662 LaMar Ave. Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/24/2005 Alexandria, VA 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 21. Signature of Funeral Service Licen pouc 4111 Pennsylvania Ave. Suitland, MD 20746 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Plart1 Immediate Cause (Final PNEUMONIA Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** KIDNEY Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Il-transit The law requires that the death certificate be executed HUMAN IMMUNODEFICIENCY VIRUS Due to (or as a consequence of) physician ar s the burial-t P.O. Box 68760 Physician/Medical as attending p IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) Yes 2 No the 9 ☐ Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ should b 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 2 No 1 Yes 2 No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ EP/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) No 1 ☐ Yes 2 No this 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 X Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation М Accident within 24 hours after deatl To the Funaral Diractor: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D48158 MARCH 18, 2005 masuresurs 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD STE 500 OXON HILL MD 20745 OXON HILL 6192 SISOM OSIA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 4, ^{Day}2005 5:45p M **Physician** Weatherly Walter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Sinai Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 16, 1903 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₽M 2□F Maryland 101 168-12-0496 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Extratists master. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 14 Yes 2 □ No Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21207 3821 Patterson Ave. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🐴 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 Specify: 3₺ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 5th College (1-4or 5+) Private Industry Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Barkley Harvey Weatherly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3821 Patterson Ave. Baltimore, Md. Adrienne L. McDaniel/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □xBurial 2 □ Cremation 3 □ Removal from State 3/9/2005 Salisbury, Md. Green Acres Mem. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22 Alexander S. Pope Funeral Homes, P.A. 5538 Marlboro Pike/Forestville, Md. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Enter the disease shock, or heart failure List only one cause on each line Immediate Cause (Final & disease or condition resulting in death) Physician Acute Renal Failure /Medical Due to (or as a consequence of): **Examiner** Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Sepsis Due to (or as a consequence of): Box 68760 attending physician iclan/Medical as the b IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant I ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. I Physi 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No To the Hospitel or Attending Physicien: 26. Place of Death Check on one 25. Was case referred to medical examiner? Be Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 2 1 ☐ Yes 2 ☑ No this 28d. Describe how injury occurred Injury at Work? 27. Manner of Death Certification: After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 21, 2005 Res-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Ave. Baltimore, Md. M.D. Douglas Ramsey, Registrar's Signature 31. Date filed (Month, Day, Year) MAR 2 5 2005 State Registrar

		-	For State Registrar	State of Maryland / Department of Maryland / D	artment of Health and N	Mental Hygien	0000	12091
	Physicia	an	1. Decedent's Name (First, Middle, Last) Ruby Wyatt			2. Date of Death Month D March 20		3. Time of Death 9:34 PM
}	/Medic Examin		4a. Facility Name (If not institution, give si Heartland Health C		4b. City, Town, or Location of Death	4	c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex			8. Date of Birth (Month, Day, Yea 7/17/1	- \(\frac{1}{2} \)	place (State or Foreign ntry) Orgia
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits
	ith the Mi or 28e-f	Director	MD Prince Ge	orge's Hyatts	10f. Zip Code	10g. C	Citizen of What Cou	
	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "neturel", or flems 23e or 28e-f show event, the M. untal Examiner must be notified at	Funeral	6500 Riggs Road 11. Marital Status 1 □ Never Married 21☑ Married	2, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	USA 14. Race - Ameri Black, White,	
-0036	2 hours aft eturel', or cal Exami	by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No Specify: Ident's Usual Occupation Skind of work done during most of work	ting 16b.	Specify: Black	
Baltimore, Maryland 21215-0036	sd within 7 giene. er than "n , the Wedi	Completed	(Specify only highest grade	lite.	me Maker		Private	
yland	2 should be filed and Mental Hygis Is markad other raumatic event, II	To Be	17. Father's Name (First, Middle, Last) Horace Cannon		Susie	ne (First, Middle, Maide Lovejoy Car	non	
, Mar	is 1 and 2 should of Health and Mer item 27 Is marks other traumatic		19a. Informant's Name/Relationship (Tyr Ruby Wyatt-Hammo	ond / Daughter 1-1	ing Address (Street and Number or Ru -3 Chickadee La.,	Adelphi, N	£D 20783	
imore	permit. Pages 1 Department of H Important: If iter eny injury or oth		20a. Method of Disposition 1 □ Mourial ↑ □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Geo. Was	hington Cem. Marc	h 28,2005		
Ball	permit Depart Import eny in		21. Signalur of Furjeral Service License	1/1001) 3	2. Name and Address of Facility La 831 Georgia Ave.,	NW, Washing		20011 Approximate
	Physician	700	shock, or beart failure. List only on Immediate Cause (Final disease or condition	Cardiorespirato		or respiratory arrest,		Interval Between Onset and Death
	/Medical Examiner	L	resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of): End Stage Dement Due to (or as a consequence of):	ia			
	and I-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
8760,	icate be axecuted physician and s the burial-transit	dlcal	L.	J				
O. Box 6	ne death certifics the attending pt thed for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{\$Z\$} \) No 9 \(\text{\$V\$} \) Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	very Day Year
S, P.	The law requires that the de ate has been signed by the a bage 2 should be detached i	by	Part II. Other significant conditions con	ntributing to death but not resulting in the	undertying cause given in Part I.	23e. Did tobacc	o use contribute to	
Vital Record	The law require ate has been si page 2 should b	Completed				24a. Was an autopsy performed 1 Yes 2 🕮	prior to co death?	opsy findings available ompletion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Others	ath (Check only one)	C DOther (Cons	
of	ding Physith. After this funeral di	tlon: To	1 Yes 2 XNo 27. Manner of Death XXNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 2 ☐ ER/Outpatie 28b. Time Injury	ent 3 DOA 4 Anuising P	dome 5 ☐ Residence 28d. Describe how in		ny)
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funarel Director: After the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	a <i>nd N</i> um <i>ber</i> o <i>r Rui</i> ate)	ral Route Number,
	To the Hospital or within 24 hours after To the Funarel Dir completely filled in	edical C	29a. Certifier 1 X Certifying Physical Control (Check only one) 2 Medical Examination	sician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place nvestigation, in my opinion, death occ	e, and due to the cause aurred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	(IA	M	29b. Signature and title of contifier	ae Clay	29c. License number 0005829		Date signed (Month) $3/22/0$, Day, Year)
	-ge		30. Name and address of person who co Suresh K. Muttat	ompleted cause of death (Item 23a) (Type h, MD 4203 Queensbu	Drint\		81	
	St Regist	ate rar	MAR 2 3 2000 (Sear)	32. Reparar's S				

		Please Type or Print in I			•	_	
		1 _ State		artment of Health and		2000	10000
		Registrar	Ce	rtificate of Death		g. NoC. UU	12095
Physi	cian	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Yeer	3. Time of Death
/Med		EDWARD GLEN WAGNER 4a. Fecility Name (If not institution, give street and number)		4h City Town and analise of Day	March	22 2005	3:12 A M
Exam	iner			4b. City, Town, or Location of Dea	iti)	4c. County of Death	1.1
Company		Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs.	. last birthday	Annapolis If Under 1 Year If Under 24 Hr		Anne Arun	
Funera Directo		213-46-8339 ¹ ∑M 2□F 62	Yrs.	Months Days Hours Min		Year) Cou	place (State or Foreign ntry)
g		Usual Residence of Decedent			DCC: 23	LJ4Z Wasi	ingcon, bo
irylar ihow	_	10a. State 10b. County 10c. Ci	ity, Town or Lo	ocation			10d. Inside City Limits
Be-f	5	MD Anne Arundel Cr	ofton				1X Yes 2 □ No
or 2	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cou	ntry?
(1215-0036 within 72 hours after death with the Maryland ene. than "natural", or itema 23s or 28e-f show than "matural" or itema 28 or 28e-f show in Medical Examilier must be indiffical at	rai	21312 Davidsonville Road	10 10	20737		USA	
er de Item	Funeral	11. Marital Status 12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White	
J36	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:		Specify:	
2 hou	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation	1	6b. Kind of Business/Ir	
215 hln 7: nn 'n	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done during most of w DO NOT use retired)	orking		
21 with a serith and a serith a serien	Completed	12		Never worked			
nd 2 be filed al Hygid d other event, II	Be (17. Father's Name (First, Middle, Last)		18. Mother's N	ame (First, Middle, M	laiden Sumame)	
laryland 21215-0036 2 should be filed within 72 hours after death with the Marylan and Menial Hygiene. Is marked other than "natural", or Itema 23a or 28e-f show aumatic event, the Medical Examinal manual by inclined at	2			Martha	Elizabeth	n Walton	
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. It is marked other than "natural", or traumatic event, the Medical Exteri		19a. Informant's Name/Relationship (Type, Print)	1.	ng Address (Street and Number or I	·		
e, N 1 and 1 Health tem 27		John W. Wagner, Jr., Brother		Chelmsford Dri			
Baltimore, IV permit: Pages 1 and Department of Health Important: If item 27 any Injury or other tr		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cre	matory or other place)		Oc. Location - City or T	
Iting it. Pa rtmer rtant		'4 □ Donation 5 □ Other (Specify) Mt 21. Sign vice of Juneral Service List each		et Cemetery 13/2		Frederick,	
Bal permi Depa Impo		21. Sign nure of Funeral Service Life Lee		2. Name and Address of Facility G			
		23a/Pan1. Enter the disease, or complications that caused the dea		739 Baltimore Av			ary Land Approximate
10.5		shock, or heart failure. List only one ause on each line. Immediate Cause (Final	. 0		as or respiratory arro-		Interval Between Onset and Death
Pnysiciai /Medica		disease or condition resulting in death)	inel	Obstruction			_
Examine	_	Due to (or as a consec	querice (ii).				
	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quence of):				
cuted od ransit	Examiner	that initiated events					
3760, ate be executed systcian and he burial-transit		resulting in death) Last Due to (or as a consec	quence of):				
876 ate by hysici	lical	d					
Box 68 leath certificate attending phy	Med	IF FEMALE:				- [
Box eath cer attendin for use	lan/	23b. Was decedent pregnant in the past 12 months?	al death 3	Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
the de sched	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of a 9 ☐ Unknown 9 ☐ Unknown	death 5t	Other (specify)			
Dd that	Completed by Physician/Med	Part II. Other significant conditions contributing to death but not re-	sulting in the I	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records, he law requires t e has been signe ige 2 should be o	D D	Organic Sprin Syndr	me		1 ☐ Yes	s 2□No 3□Pro	bably 4 Donknown
cord: w require been sig	lete				24a. Was an	24b. Were aut	opsy findings available
Re(he lav	g mo				autopsy perform	prior to co	empletion of cause of
	a)	25. Was case referred to medical		26 Place of D	1 ☐ Yes 2, eath (Check only one	No 1 Yes	2 NO
ysich ysich is cer direct	OB	examiner? 1 Yes 2 No Hospital: Inpatient 2	☐ ER/Outpatie	Othor		nce 6 Other (Speci	fv)
Vision of Vita Attending Physician: r death. ector: Atter this certific by the tuneral director.	T:U	27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)	28b. Time o		28d. Describe how		
ision (ttending P death. ctor: Atter i	atic	2 Accident investigation		M 1 Yes 2 No			
Division of to Attending Phy after death. Director: Atter this din by the tuneral d	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be building, etc. (Special Could not be building, etc.)	nome, farm, st	reet, factory, office	28f. Location (Streetly or Town,	eet and Number or Rur , State)	al Route Number,
Ditat of urs at paral Dilled ii	O						
Hospitat 24 hours Funeral stely filled	dical	29a. Certifier (Check only 0 Check only 0 Check only 0 0 0 0 0 0 0 0 0 0	lowledge, deal lation and/or in	th occurred at the time, date and pla nvestigation, in my opinion, death oc	ce, and due to the car curred at the time, da	use(s) and manner as : te and place, and due t	stated. o the cause(s)
Div To the Hospitat or within 24 hours afte To the Funeral Dir completely filled in I	Med	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month,	Day, Year)
H 3 H 8		*I (1)	NO	2000-7/2		MAR 22	. 2005
1300		30. Name and address of person who completed cause of death (Ite	em 23a) (Type	Print)			
18	8	Tim WOURS 2001 med	1	Porkan A	napolis	MO	21401
and the same of th	tate	31. Date filed (Month, Day, Year) 32. Registrar's Skip MAR 2 5 2005	ature	0			
Regis	strar	MAK & J LUUJ Blow JA					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month O3 OS LINDA LEE PENNINGTON YOUNG 10:00 RM /Medical 4a. Facility Name (If not institution, give street and number)
GARRETT CO. MEMORIAL HOSPITAL 4c. County of Death Examiner OAKLAND If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F 43 PARSONS. 235-96-6849 Yrs. **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Medical Examinating Legicalities at TUCKER WV THOMAS 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HC 60 BOX 98 26292 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: WHITE 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglent Importent: If item 27 is marked other the any injury or other treumatic event. Its 2006. DISABLED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CARROLL RAY PENNINGTON ELISE LORENE REED 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO BOX 213 THOMAS, WV 26292 19a. Informant's Name/Relationship (Type, Print) PO BOX 213 THOMAS, WV CARROLL PENNINGTON, JR 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State DAVIS CEMETERY 4-7-05 DAVIS, WV *4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligense INC. BOX 186, DAVIS WV 26260 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine led by the attending physicien and detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate 2 □ No 1 ☐ Yes 2 ☐ No 1 Yes within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, i 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1006(801 une 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) guital, oakland 311 NiFourth ENR. Buczurek1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/200

Registrar

APR 0 8 2005

			For	State of Ma		epartme	nt of H	ealth and	-	giene,	
			1 - State Registrar		(Certifica	te of L	Death	-	Reg. No	19 1508/
п	Physici		Decedent's Name (First, Middle, L	Ter.	esa	Voc	uw	7	2. Date of De	Day	Year 60(-5:15 P M
	/Medic Examir		4a. Facility Name (If not institution, g.		<u> </u>	4b. Cit	y, Town, or	Location, of Dea		4c. County	
	•		5t. Glizabett	n Nursing	Cente	· /	13	altin	nove	Non	e
	Funeral Director			4 M M 7897 C	(In yrs. last birth	Month:	er 1 Year Days	If Under 24 Hr Hours Mir	n. (Month, Da	th ly, Year)	Birthplace (State or Foreign Country)
	D		213 03 6134 Usual Residence of Decedent						Apr 24	, 1905	New York
	be filed within 72 hours after death with the Maryland nal Hygiene. Id other than "natural, or items 23a or 28e-1 show event, the Midral Exam her must be notified at	J.	10a. State 10b. County		10c. City, Town						10d. Inside City Limits
	the M 28a-1	Funeral Director	MD Howard 10e. Street and Number	<u> </u>	Colum		lip Code			10g, Citizen of W	1 Yes 2X No
	3a or	i Di	7080 Cradlerock	Way #316			21045			-	d States
	items 2	nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.			spanic Origin? (Specify Yes or No rto Rican, etc.)		e - American Indian,
36	s after , or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ∑XN If Yes, Give	0		2 X No	Specify:	ito i ilozii, etc.)	Specify	k, White, etc.
9	2 hour atural	ed b	15. Decedent's I	Year or Dates:	16a. E	Decedent's Us	ual Occupa	ition		16b. Kind of Bu	White
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21	filed within Hygiene. Ither than "		47.5-1-1-1-1	2		cretar				Bankin	
Maryland	buid be fi Mental H arkad oti atic ever) Be	17. Father's Name (First, Middle, Las John Lappin	t)				Mary Na	ame <i>(First, Middl</i> e, ach	Maiden Sumam	θ)
ary	<u> </u>	ဥ	19a. Informant's Name/Relationship	(Type, Print)	19b. I	Mailing Addre	ss (Street a		Rural Route Numbe	er, City or Town,	State, Zip Code)
	th a		Charles E. Yokum	/Son	480	05 Carr	nan Di	rive Ell	licott Ci		
Baltimore,	Pages 1 and nent of Healt int: If Item 2 iry or other		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3	☐Removal from State	20b. Place of I cemetery,	Disposition (National Control of	ame of other place	9)	Date	20c. Location -	City or Town, State
ţ			`4 ☐ Donation 5 ☐ Other (Spec	ity)		Cremat				Catonsv:	
Ba	permit. Departr Importa any nj		21. Signature of Funeral Service Lice	-1461	M01044	/1110 (and Address	s of Facility Ha Slumbia	erry H. V	Witzkes 1	Family FH Inc. ity, MD 21043
	_		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused	the death. Do no						Approximate Interval Between
M	Physician		Immediate Cause (Final disease or condition		ment	-i'a					Onset and Death
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	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		140						
ó,	cate be executed oblysician and the burial-transit	i Exa	resulting in death) Last	Due to (or as a	consequence of):					
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Box 6	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d Date	a of delivery
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P.0	at the de t by the a stached	Phys	9 🗆 Unknown	9□ Unknown							
	ires that signed t	by	Part II. Other significant conditions	contributing to death bu	t not resulting in t	he underlying	cause give	n in Part I.			bute to the cause of death?
Sor	w requir been si should	etec	Himordia	0.100.2					:		
of Vital Records,	he lav e has age 2	ompieted	ryperipro	EMIC						rmed2 de	Vere autopsy findings available for to completion of cause of eath?
ita		Be C	25. Was case referred to medical					26. Place of De	1 ☐ Yes eath Check onl o		☐ Yes 2☐ No
∑ <	Physician: this certific ral director,	ToE	examiner? 1 Yes 2 No		it 2□ER/Outp			4 United Sing I	Home 5□Resid	lence 6 Othe	r (Specify)
uc	ding P	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tin	ne of ury M	28c. Injury Work	at ? es 2 □ No	28d. Describe !	now injury occurre	bed
Division	or Attending after death. Director: After in by the funer	ifical	2 Accident investigate 3 Suicide 6 Could not determine	be 28e. Place of Injur	ry - At home, farm			65 2 110	28f. Location (S	Street and Numbe	or or Rural Route Number,
á		Certification	4 Homicide determine	building, etc.	(Specity)				City or Tox	m, State)	
	To the Hospital or within 24 hours after to the Funeral Discompletely filled in	edicai	(Check only 2 Medical Exa	hysician: To the best of	examination and/	death occurred	d at the time	e, date and placi inion, death occ	e, and due to the ourred at the time,	cause(s) and man	nner as stated. nd due to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stat	ed.		9c. License				(Month, Day, Year)
	ઇ ન ર ⊣			nin	mo		-	5530	0		22,2005
\ ^.	7		30. Name and address of person who	completed se of de	ath (Item 23a) (T	ype, Print)	10				1 -
) ⁽¹	ν		Ming Vi 33		ISON A	venu	12	15014	imore	Mary	land 2122]
	Sta Registr		31. Date filed Month, Day, Year)	2005 32. Resistra	s Signature	Anair	6.0			1	

	تنجي	Registrar 1. Decedent's Name (First, Middle, i	(ast)	Cel	tificate of Death	2. Date of E	Reg. No.		3. Time of De
Physici	an	Daryl Linden				Month	Day		
/Medic		4a. Facility Name (If not institution,			4b. City, Town, or Location of	Marc]		2005 County of Death	7:30 p.
Examin	er	Western Maryla	· · · · · · · · · · · · · · · · · · ·	nter	Hagerstown	Death		ashingto	
				s. last birthday)	If Under 1 Year If Under 24	Hrs. 8 Date of F			
Funeral Director		218-62-8780	1X M 2 □ F	49 Yrs.	Months Days Hours	Min. 8. Date of E (Month, 1 Feb 2	Qay, Year)	56 Mai	nplace (State or Fo untry) ryland
JII EC (OI		Usual Residence of Decedent		77		100 2	, 1).	114.	Lyrand
show ed at		10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City L
r 28a-f show notified at	ō	Maryland Freder	ick Br	unswick					1 Tes 2
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ms 2	Funerai	11. Marital Status	12. Was Decedent Ever in	U.S. 13. V		n? (Specify Yes or I		14. Race - Amer	rican Indian.
The The	Ē	1 ☐ Never Married 2 Married	Armed Forces?	1	Vas Decedent of Hispanic Origin f Yes, specify Cuban, Mexican,	Puèrto Rican, etc.)		Black, White	
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atura E E	e	15. Decedent's	Education	16a, Deced	lent's Usual Occupation			nd of Business/l	
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event, the Me		17. Father's Name (First, Middle, La	ist)			s Name (First, Midd	_1		
D 0	o Be	Lewis Zombro				Kerns		,	
mark	ဥ	19a. Informant's Name/Relationship	(Tyne Print)	19h Mailir	g Address (Street and Number	or Rural Route Num	her City of	Town State 7	in Code)
Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Morea.									ip code)
eall sm 2 ther		Evonne H. Zombro 20a. Method of Disposition		610 S . Place of Dispo	ouder Road Brus			⊥6 cation - City or l	Four State
2 = 2		1 ☐ Burial 2 ☐ Cremation 3	Removal from State	cemetery, cren	natory or other place)	archate25,	-		
lury		' 4 □Donation 5 □ Other (Spe			1 Crematory	2005		ton, Mai	
ny in		21. Signature of Funeral Service Lic	censee \ \ \	Ğ	Name and Address of Facility Oing Home Crema	ation Ser	vice	P.O. Bo	ox 784
고도등려		Devely I	Helles MOI	251 B	everly L. Heck	rotte, P.	A. Cla		
		23a. Pert1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the de	eath. Do not ent	er the mode of dying, such as ca	ardiac or respiratory	arrest,		Approximate Interval Betwe
sician		Immediate Cause (Final disease or condition	Sepsis					Į.	Onset and Dea 2 weeks
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DHMH 17 Rev 1/2001

			1 - For State Registrer	State	of Marylan		artment of H			/	5 12099
			Decedent's Name (First, Middle	e, Last)			imouto or i	Journ	2. Date of Dea	leg. No.	3. Time of Death
	Physici		David Lo	ng Bot	vers				April 4	Day 2005	2:25 P M
	/Medio Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of Dea		4c. County	
			Anne Arundel	Medical (Center		Annap	olis		Anne	Arundel
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h Yearl	Birthplace (State or Foreign Country)
	Director		223-44-1929	1 XM 2 ☐ F	68	Yrs.	Months Days	HOUIS MIKE	Nov. 3,		Virginia
	pu &		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	antion				10d. Inside City Limits
	sho sd et	ō	, out out of		100. 01	y, 1041101 <u>2</u> 0	oation				1 Yes 2X No
	the N	Director	Maryland Anne	Arundel_		Se	Jern 10f. Zip Code			10g. Citizen of W	
	with the or			_				144			States
	leath ns 23	Funerai	374 Anna Cour		cedent Ever in U.	S. 13. V			Specify Yes or No-		- American Indian,
(0	r Iter	F	1 ☐ Never Married 2 ☐ Mar	Armed I	Forces?		Was Decedent of Hi f Yes, specify Cuba		rto Rican, etc.)	Black	k, White, etc.
ဇ္ဇ	ral', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yas (aive Dates:		I∐Yes 2∏XNo	Specify:		Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Ital Hygiene. d other than "natural", or Items 23s or 28e-f show event, I're Modical Exerts at must be notified at	Completed	15. Deceden (Specify only highe	t's Education	4)	16a. Dece	lent's Usual Occupa	ation	ndkina	16b. Kind of Bu	siness/Industry
7	ithin Jen.	npie	Elementary/Secondary (0-12)		(1-4or 5+)	life.	OO NOT use retired)	, italy		
	led w lygier lygier her ti		47. 5-15-4-14- (5-1-44-14)		yr	Sy	stems Ana				1 Security Age
and	be fill be fill be defined by the fill be of the fi	Be	17. Father's Name (First, Middle,					_	me (First, Middle,		θ)
Maryland	hould d Mei mark natic	2	Aquilla D. 19a. Informant's Name/Relations	Bowers		10h Mailin	n Addrson (Ctroots	Susan		long	State Tie Codel
Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, Ite Medical Examinat must be notified at any injury or other treumatic event, Ite Medical Examinat must be notified at anotice.		Elizabeth A. Bo		۵		g Address <i>(Street a</i> nna Court		n, Maryla		
	1 an Heal Iem 2		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of		Date		City or Town, State
Baltimore,	ages ant of t: If II		1 Burial 2 Cremation 4 Donation 5 Other (5		n State C	emetery, cren	natory or other plac	1	/2005		
ቜ	nit. P artme orten injur		21. Signature of Funeral Service		MD	22	ns Cemete . Name and Addres	s of Facility			ille, Maryland
ñ	permi Depar Impor any ir	h 1	Domenico (modeo	MO14	or Do	naldson F	uneral :	Home & Cr	ematory	1and 21113
			23a. Part 1. Enter the disease, or	complications that	t caused the death	12 7					Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on	1014 N	24					Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	o (or as a consequ						TON
	Examiner			b							YC94
	D ==	ner	Sequentially list conditions, if any, leading to intractions cause. Enter Underlying	Due to	o (or as a nonseq	uence of):					
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8760,	cate be executed physician and the burial-transit	Ē	resulting in death/ cast	Due to	o (or as a consequ	uence of):					
87	icate be executed physician and s the burial-transit	dicai		d		-					
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Вох	atten for u	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1□Live	birth 2 Fetal	ideath 3□	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery ith Day Year
P.O.	the d y the	isku	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk			Cartor (openny)				
<u>. </u>	s that ned b	y Pł	Part II. Other significant condition	ons contributing to	death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
rds	quire n sig uld be								1 □ Y	es 2 No	3 ☐ Probably 4 ☐ Unknown
00	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Completed							24a. Was a	an 24b. W	Vere autopsy findings available
æ	The lav	mo							autop perfor	mejer? d	rior to completion of cause of eath? □ Yes 2 No
Vital Records,	ysicien: The lis certificate hadirector, page	BeC	25. Was case referred to medica examiner?					26. Place of De	ath (Check only or		21.00
	Physic this ce al dire	To	1 Yes 2 No	Hospital:	Inpatient 2 🗆	ER/Outpatien	t 3□ DOA Othe	4 Nursing	Home 5□Resid	ence 6 □Othe	or (Specify)
D L	Attending Physicien: r death. ector: After this certifica		27. Manner of Death 1 ☑ Natural 5 ☑ Pendir	/A 4m	e of Injury onth, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe h	ow injury occurre	ed
sio	tendi leath. lor: A the fu	cati	2 ☐ Accident investi	gation				res 2□No			
Division of	l or Attendate death Olrector:	Certification;	4 ☐ Homicide determ	tined 286. Flat	ce of Injury - At ho ding, etc. (Specify	ome, farm, str v)	eet, factory, office		City or Tow		er or Rural Route Number,
_	pitel		29a. Certifier 1 Certifyin	ng Physician: To th	he best of my kno	wlodge death	coourad at the time	o data and place	a and due to the	and and	
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edicai	(Check only 2 Medical one)	Examiner: On the	basis of examination	tion and/or inv	restigation, in my op	pinion, death occ	urred at the time, o	iate and place, a	nd due to the cause(s)
	ro th within ro th	Me	29b. Signature and title of certifie	220			29c. License	number	2	29d. Date signed	(Month, Day, Year)
b	10	-	D 14-1	UVI	10		000	51301	1	April	4, 2005
X	1-1		30. Name and add ss of person	who completed car	use of death (Item	23a) (Type,	Print)	011	1	reference con	4, 2005 is, MOZIYU
\bigcirc			Kenn Blo	ropt 1	40 90	00 60	styget ,	10 As	00 TO	mapoli	15 NIV 2144
	Sta	-	31. Date filed (Month, Day, Year)	32.	Registrar's signa	ture	- Goodes				
	Registr ———	ar	ħ.	DR 1 1 20	US ARRES	Real of	- 6				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Thomas A. Bush Narch 29, 2005 6:30 AM /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9165 Bourbon Street #K Laure1 Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1X M 2 □ F 110-34-1488 Yrs. 1943 61 Sept Director 1, New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene Important: If item 27 le marked other then "naturel", or Items 23a or 28a-f ehov any injury or other traumatic event, the Mudical Examiner count be notified at once. MD Howard 1 ☐ Yes 2X No Laure1 Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 9165 Bourbon Street #K 20723 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces:
1 Xes 2 No
If Yes, Give
Year or Dates: 166-82 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) environmental worker USAF 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Franklin P. Bush Elizabeth J. Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9165 Bourbon Street #K Laurel, MD Mary Bush/spouse 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 21. Signature of Furneral Sirvice Licenter 12 \$2. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street naun 23a. Pant. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Interval Between Immediate Sause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetel death Day signed by the atte Month Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 □Unknown Yes 2 🗆 No as been sign 2 should b Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No has certificate ha 1 ☐ Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 1 Yes 2XNo 5 esidence 6 Other (Specify) Medical Certification: To 4 Nursing Home 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 □ Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funaral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 145014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRT MD 8343 Citiley ISABELLA

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2005

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** APRIL 7, 2005 ear 12:30 AM RUTH ANN BECKWITH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BRIGHTWOOD LUTHERVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1□M 21X Months Days Hours 216-16-5901 84 Director 01-19-1921 MARÝLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2√CYNo Director MD. BALTIMORE LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 BELLOWS COURT 21204 or Items 23e U. S. A. Pages 1 and 2 should be filed within 72 hours after death nent of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 YEARS McCORMICK COMPANY College (1-4or 5+) OFFICE MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENJAMIN SR. Η. BECKWITH, **EMILY** ပ္ LONG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BENJAMIN H.BECKWITH (BROTHER) 23 BELLOWS COURT, TOWSON, MARYLAND, 21204 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) injury or permit. Page Department of Important: If eny injury or once. 05-09-2005 BALTIMORE CEMETERY BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 w 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA Priysician YR. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE use If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2XXX0
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 þe 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2**)(**\)\(\)\(\)\(\) Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 1 ☐ Yes 2√2 No Certification: To Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred t**X**Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier VIX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) APRIL 777945 7, 2005 MD de 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21204 MO 7505 OSLEW DAW & TOWSON ARIS 31. Date filed (Month, 32. Régistrar's Signaturé Carried States Registrar

		1	For State Registrar	State o	f Marylan		artment			and M		giene Reg. No.	2005	12102
	Physicia		1. Decedent's Name (First, Middle, Li Edward Lambert]	-	Jr.						2. Date of Dea Month 04	Day	Year 2005	3. Time of Death 4:30p
	/Medic Examin		4a. Facility Name (If not institution, gi				4b. City,	Town, or	Location of	of Death		T	County of Deat	
			Potomac Manor Ca	are				toma					lontgom	
i i	Funeral Director		004-40-0261	Sex †√∑M2□F	7. Age (In yrs. 82	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da 11-18-	1922	9. Birt Co	hplace (State or Foreign Juntry) New York
	ow I	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	a-fah	tor			W	ashing	ton D	C						1. Yes 2 No
	or 28	Funeral Director	10e. Street and Number	na MI			10f. Zip					-	en of What Co	ountry?
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220	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inferiorati if them 27 is marked other than "natural", or items 23a or 28a-f ahow eny injury or other traumatic event, the Medical Examinating the multipled at ODGe.	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed F	orces? 19 2 No 19	7.2	lf Yes, spec 1 ☐ Yes 2		Specify:		ecify Yes or No Rican, etc.)		Black, Whit	e, etc. hite
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ē	Physician /Medical Examiner	Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Bila Due to	teral A (or as a consecting on section as a consection as a co	Disea	se	neum	onia					Interval Between Onset and Death
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 ← Certifying (Check only one) 2 ← Medical Ex	Physician: To the and ma	ne best of my kn basis of examin nner stated.	owledge, dea ation and/or in	th occurred nvestigation	at the tin	ne, date a pinion, de	nd place, ath occur	and due to the red at the time.	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
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	he Marylan 8e-f show otified st	ector	MD Carro	L1	1	y, Town or Lo Sykesv	ille								od. Inside City Limits 1 ☐ Yes 2X No	
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-0036	2 hours afte aturel", or it cal Evamin	þ	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's 8	1 □ Yes 2 ☑ If Yes, Give Year or Dates		16a. Dece	1 ☐ Yes :	2∭ No al Occupa	Specify:				Specify:	wh	ite	k
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Amend item#19a, perrH, C842, 4/11/05 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2005 **Physician** APRIL 6, FIOLA **BLUM** 10:46 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11 SLADE AVENUE #903 BALTIMORE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year JUNE 4, 1911 Birthplace (State or Foreign Country) **Funeral** Min 1□M 2QF Months Days Hours 216-28-6775 93 Yrs MD Director Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location worde, 10d. Inside City Limits Item 27 is marked other then "natural", or iteme 23a or 28e-f ebor other treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 👿 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 SLADE AVENUE #903 21208 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after in and Mental Hygiene. Is marked other then "natural, or Ite! 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify 3 X Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **BROKER** REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SHAPIRO MINZ BERNARD CECILIA 2 19a. Informant's Name/Relationship (Typ).
HARRY BL-UM / TSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si ment of Health and ant: If Item 27 Is r 2306 SUGARCONE ROAD - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ö 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. *4 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP. 04/08/2005 TOWSON, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial INFORCTION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 10 Cular Lego 1 Yes 2 X No 2 X No 1∏ Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 1 🗌 Inpatient ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation s after de... rel Director: Air tv the fi 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funerel DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State

Registrar

31. Date filed (Month, Day, Year)

1 2005

32. Registrar's Signature

				epartment of Health and M Certificate of Death	Mental Hygie	0 0 0	12105
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last) Clarifa A. Cooper		2. Date of Death Month	Day Year 2005	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, give street and number) Nov thwest Hoppton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	4b. City, Town, or Location of Death Randalls + 5 m (ay) If Under 1 Year If Under 24 Hrs.		Scul + M (Place (State or Foreign
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5-0036	d within 72 hours after death with the Marylan liene. r than "natural", or items 23a or 28a-1 show The Medical Examinet must be notified at	by Funeral	11. Marital Status 1 Never Married	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2♥ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Bla	etc.
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Sammore	nit. Pages 1 a artment of Hea ortent: If Itam injury or otha		20a. Method of Disposition 1 1 ☑ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition Cemetery, Druid	cromatoni or other place)	4/05	Location - City or To kesville	
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VIG	di S	lo Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ NO	26. Place of Death	n (Check only one) me 5 ☐ Residence	6 □Other (Specifi	ν)
0 10	fte	ertification; T	27. Manner of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Tim. Injure	e of 28c. Injury at	28d. Describe how in		
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta		l Route Number,
	ha Hospi n 24 hou ha Funer pletely fill	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, de control on the basis of examination and/or and manner stated.	eath occurred at the time, date and place, a rinvestigation, in my opinion, death occurred.	and due to the cause ed at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
	Tot Com	Σ	29b. Signature and Little of certifier	29c. License number 0 36819	29d. [Date signed (Month,	Dey, Year) 2005
	10		30. Name and address of person who completed cause of death (Item 23a) (Type Patricia Home Melfor W	De. Print) Northwa	15toN	pital	
ı	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Carle			*

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	1. Decedent's Neme (First, Middle,	Lest)		Ochince	ato or E	,caiii	2. Dete of D	Reg. No.		3. Time of Dea
Physician	Dened d	. 1 1	0 1				Month	Day	Year	
/Medical	David I 4a Facility Neme (If not institution,	Molina give street end nur	Cordo	ova	48	o. City, Town	April n, or Location of Dea			11:15
Examiner										,
	Prince George :	s Hospita 6. Sex	.1 Cente 7. Age (In yrs.	last birthday) If Un	der 1 Year	Cheve If Under 24	Hrs R Date of B	irth	ce Geor	
Funeral Director		1 X M 2□ F	go (y.o.	Yrs. Month	s Days		Min. (Month, D	ay, Year)		e (State or Fo
6	n/a Usual Residence of Decedent					6	April	2, 2005	Mary.	Land
land	10a. Stete 10b. County		10c. Cit	ty, Town or Location					10d.	Inside City L
Many to	Nr. 7 1	. 1 1								1 ∏ Yes 2 □
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urs aff	1 Never Married 2 Marrie 3 Widowed 4 Divorced	ed 1 ☐ Yes If Yes, Giv Year or Da	/e	17√∑ Yes	2 □ No	Specify:		Specif		
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ygiene. Ner then "neturn tt, the Medical I	15. Decedent's (Specify only highest	grede completed)		(Give kind of	work done di	urina most o	f working	100. Kind of B	usinessindusi	ury
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C A Spied	n/a 17. Father's Name (First, Middle, L	netl			n/a	10 Mothodo	Name (First, Middle		/a	
d 2 should be filed within 72 hours after death with the Manylan thend Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at To Be Completed by Funeral Director		•					,		110)	
Men Men To	Emmanuel Coutin		a				Molina Ca			
2 sh end ls m	19a. Informant's Name/Relationshi						or Rural Route Numi			de)
5 2 2 5	Emmanuel &Elsa	Cordova/p								
Peges 1 e nant of Hea int: If Item iry or othe	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	2 C Domoval from 6	20b. F	Place of Disposition (formatory of	lame of r other place)	Date	20c. Location	- City or Town,	State
Peg nant nant: In int: In	4 Donation 5 Other (Spi	ecify)		Arundel C	remato	ry	4/11/05	Odent	on, Mai	ry1and
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Examiner	resulting in death)				PULL	1se			i	
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		State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2005									12107			
1	Physicia	an	Decedent's Name (First, Middle, E	٧.	/. CARTERA					2. Date of Death Month Day Year APRIL 02 2005 0				
	/Medic Examin	al	4a. Facility Name (If not institution,	CARTE	4b. City, Town, or Location of Death					County	03:10 PM			
			SAINT AG					iti	MOR				N/A	
	Funeral Director		5. Social Security Number 214-82-8641	6. Sex 7. Ag 1 ☐ M 2 X7. XF	ө (In yrs 97	s. last birthday) Yrs.	Months Months	1 Year Days	Hours M		rth a <i>y, Year</i> -100) 7	Cou	place (State or Foreign ntry) IPPINES
	70		Usual Residence of Decedent							107-13	130			
	/ary∤ar I show	Į.	10a. State 10b. County 10c. City, Town or Location BALTIMORE									10d. Inside City Limits XXYes 2 □ No		
	r 28a-f	rect	10e. Street and Number		1		10f. Zip				10g. C	tizen of	What Cou	ntry?
	ath with	raiD	206 WEST LO	RRAINE AVE					211				S. /	
36	iii. Pages 1 and 2 should be filed within 72 hours after death with the Maryland priment of Health and Mental Hygiene. Ordent: If Itam 27 is marked othar than "natural", or itams 23a or 28a-f show injury or other traumatic event, the Medical Examinar in that be notified at 6.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie XX Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Y 1 Yes, Give Year or Dates:			Was Deced If Yes, spec 1 ☐ Yes		panic Origin? Mexican, Pu Specify:	(Specify Yes or Neto Rican, etc.)	0-		ick, White,	can Indian, etc. NHITE
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Baltimore, Maryland 21215-0036	d be filed antal Hygic ced othar c event, IL		17. Father's Name (First, Middle, L JUAN VI							lame (First, Middle		n Surnai	me)	
aryl	should and Me s mark		19a. Informant's Name/Relationsh	ip (Type, Print)					d Number or	Rural Route Numb	er, City			
≥	l and 2 tealth im 27 in her tre		CONCEPCION C.DER	ROSARIO (D		Place of Dispo	-		NT VAL	LEY DRIVE			,MD .	
nor	ages ant of H it: If ite y or of		20a. Method of Disposition X ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from State		cemetery, cred	matory or of	ther place)	- 1	14/05				RYLAND, 21093
Baltir	permit. Pages Department of Important: If it any injury or of once.		21. Signature of Funeral Service L	icensee	G.RU	2:	2. Name and	d Address	of Facility	AL HOME,		105	ח עחב	DK DUND
	Physician /		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death
0			Immediate Cause (Final disease or condition resulting in death) A. Preumonia Due to (or as a consequence of):										20445	
	Examiner		COPO											YEARS
	D it	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause to leaded or injury	Due to (or as	or as a consequence of):									
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QUE O. Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 live hirth 2 Fetal death 3 Fetonic pregnancy								ate of delive onth		
SP	requires that the een signed by th nould be detache											co use contribute to the cause of death?		
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ARTI Division	Attanding Physiclan: r death. sector: After this certific. by the funeral director.	ication	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rura City or Town, State)									al Route Number		
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0	To the Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifier (Check only one) 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the I within 2 To the I	Σ	29b. Signature and title of certifier	11.	- 0	201	29c	License r		2 -			ed (Month, 2/20	Day, Year)
	7		30. Name and address of person v	who completed cause of c	leath (Ite	em 23a) (Tvna	Print)		1746					
0	<u></u>		SANJAY	VNJAMA 32 registr 2005	RAN	4 MO	900	cah	an A	ve Ba	Cfor	409	re,	ND 21229
	Stat Registra		31. Date filed (Month, Day, Year)	32 Registr	ar's Sigr	nature	and i			,			/	
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			Decedent's Name (First, Middle)	, Last)	<u> </u>		moat	COIL	Joann		2. Date of Dea			3. Time to	of Death		
	Physici /Medi		Geraldine Ro	semary	Cole						APRIL	3.	2005 Year	1502	M		
1	Examir		4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City,	Town, or	Location of	of Death			County of Deat		- Р		
			2500 W. BELVEDERE AVENUE BALTIMORE CITY														
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$						If Under Hours	er 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) CT							
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, it a Madical Examination must be notified an once.		Jsual Residence of Decedent 0a. State 10b. County 10c. City, Town or Location											10d. Inside City Limits			
		៦	MD			altimo		1 + 17							2 □ No		
		Funeral Director	10e. Street and Number		150		10f. Zip					IDa, Citi	izen of What Co	untry?			
		<u>-</u>	2500 West Belvedere Ave., Apt 21209										S.A.	,			
21215-0036		nere	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pure 15. 15. 15. 15. 15. 15. 15. 15. 15. 15.					gin? (Spe	ecity Yes or No-		14. Race - Ame						
		by	1 Never Married 2 Married						i, Puerto	Hican, etc.)		Specify: Wh	ite				
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21		nple	Elementary/Secondary (0-12)	life DO MOT use setimed)						OI WOIN	ing						
		ပိ	12										Nursing Home				
and	be fi	Be	17. Father's Name (First, Middle, I	Last)					18. Mothe	r's Name	e (First, Middle, I	Maiden	Sumame)				
Maryland	d Mer nark	우	10a Informantia Nama/Balatianat	sin (Time Ovint)		105 14-15		101				-					
	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 223 Coronet Dr., Linthicu														
	1 an Heal tem 2		20a. Method of Disposition	011	20b. I	Place of Dispo	sition (Nan	ne of				_	cation - City or		-		
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 ☐ Burial 2 🗷 Cremation 4 ☐ Donation 5 ☐ Other (S)		State	cemetery, crer	natory or o	ther place	'	04/							
		- 1	21. Signature of Funeral Service I		De						05/05 I J.Gonce				DΔ		
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	cate be executed hypergraphic cate by the buriat-transit the buriat-transit cate of the buriat-buri		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea								01147 11	Approximat	te		
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x 68760,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	dlcal		d													
		/Me	IF FEMALE:						20 d D - 4 - 4 - 15								
Box		Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 No 2 No 2 St. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								23d. Date of delivery Month Day Year						
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Records, P.		by P	Part II. Other significant conditio	rt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of death?				
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oc c		Be Completed									24a. Was ai		24b. Were aut	opsy findings ompletion of c	available		
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			25. Was case referred to medical examiner? 26. Place of Death Check onlone										10 10 2010				
of V	dis y	2										T					
Division o	ding h. After fune	Certification;															
			2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route N														
Σ	or All	i ii	4 ☐ Homicide determi	200. Place	ing, etc. (Special	ome, tarm, stre	et, factory	, office		2	28t. Location (Sti City or Town	reet and , State)	d Number or Rui	al Route Num	ber,		
۵	ospital hours uneral ly filled		29a. Certifier 1 ☐ Certifying	Physician: To the	a bact of my kno	owledge death		at the time	a data as a	l ninna a							
	124 H	Medical	(Check only 2 Medical E	xaminer: On the b	easis of examination and stated.	ation and/or inv	estigation,	in my opi	nion, deat	h occurre	ed at the time, da	ate and	place, and due	stated. o the cause(s)		
	To the within To the Comple	Me	29b. Signature and title of certifier				29c	License	number		29	9d. Date	signed (Month,	Day, Year)			
	, , , , , ,			M	1/	far	00	ME			AT	דד מַנ	4, 200	5			
•	2	-	30. Name and address of person v	vho completed caus	se of death (Iter	n 23a) (Type. I		خلايه			112	LILL	ı ¬, ∠00	<i></i>			
			m. Ko	rell Mi	7).			1 Pe	nn St	reet	t Balti	mor	e. Marv	Land 21	201		
	Sta		31. Date filod (Month, Day, Year)	32.	Registrar's Signa	ature											
	Registr	ar	APR 11	2005	segistrar's Signa	g go	Mes!										

			1 - For State Registrar	State of	Maryland		artmen <i>rtificate</i>				lental Hy	giene Reg. No.	200	5 12	109
	Physici	an	Decedent's Name (First, Middle	e, Last)							2. Date of De Month	ath Day	Year	3. Time of	Death
	/Medi				aret An	n Dove					April	· -		5:05	A ^M
	Examir	ner	4a. Facility Name (If not institution		oer)		·		Location of	of Death					
			Laurel Regiona 5. Social Security Number		Age (In yrs. la	et hirthday)	Lau:		If Under	24 Hrs.	8. Date of Bird	h	O Bie		Comina
	Funeral Director		213-42-6784	1□M 2⊠F	79	Yrs.	Months		Hours	Min.	Oct 30	y, Year) • 192	_ Co	hplace (State or untry) hington	-
	ס		Usual Residence of Decedent										ay Year 2005 c. County of Death Prince Ge 9. Birth Co. Wash Proceedings of Wash Procedure of Wash Procedure of S.A. 14. Race - Amer Black, White Specify: Whi inicipal partment of Sumame) OW or Town, State, Zing and 21144 cocation - City or Tentwood, 23d. Date of delive Month Prince of Sumame of Prince of Sumame of Prince of Sumame of Sumame of Prince of Sumame	ii I II g coii	, 50
	ihow	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside Cit	
	Ba-f s	cto	MD Prin	ce George	Lau	rel								1 🗌 Yes	2 🔀 No
	ith th	Dire	10e. Street and Number				10f. Zip							untry?	
	s 238	Fra	9268 Cherry La		Ci- 11 6		1	708		-1-0 (0.				t	
	ter de Itam Iner	Funeral Director	 Marital Status XNever Married 2 Married 	12. Was Deced Armed Force ried 1 □ Yes 2	es?	s. 13. V	f Yes, spec	ent of His	n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	- '			
036	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes Give			1 ☐ Yes 2	2 X No	Specify:				Specify: Whi	.te	
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show lical Examinar must be notified at	Completed	15. Deceden	t's Education st grade completed)		16a. Deced	ient's Usua	I Occupa	tion	t of work	na				
21	ithin nan Mag	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	kind of wor DO NOT us	e retired)	uning mos	COI WOIK	, ig				
121	iled w tygier her ti		12 17. Father's Name (First, Middle,	(ant)		Accou	ıntanı		10 Matha	ula Mana	(Friend Adiabatic	<u>-</u>		-	
Maryland	d 2 should be fi th and Mental H 7 is markad ot traumatic evar	Be c	Lester Linwood	ŕ											
Z	should nd Me mark matic	2	19a. Informant's Name/Relations			19b. Mailin	na Address	(Street a			abell F			in Code)	
	nd 2 sulth ar			/cousin										,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
ē,	s 1 au f Hea itam otha		20a. Method of Disposition		20b. Pla	ace of Dispo					ate 2			Town, State	
E	Page nent o int: If		1 XBurial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (S		ate	Linc			1	Apr]	13, 05	Bren	twood.	Marvla	nd
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ire Modical Examiner must be nuitled at 9068.		21. Signature of Funeral Service	Licensee	M007				s of Facilit Fune	ral	Home, P	.A.	a 554500 ST	Ten in print	8
	Physician		23a. Part1. Enter the dis lace, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on eac	sed the death. th line. myocar					cardiac o	r respiratory a	rest,		Approximate Interval Betwoonset and D 2days	eath
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	ence of):									
	Examine	<u>.</u>	Sequentially list conditions,	b. Sepsis	as a consequ	+D								2days	
	ted	nine	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Pneumo		ence or,								2days	
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8760,	icate ba executed physician and s the burial-transit	dical Examiner		d. Type 2	diabe	tes								10year	s
P.O. Box 6	law requires that the death certificate ba executed so been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown		h 2□Fetal nt at time of de	death 3	Ectopic pro Other (spe					23		*	ear
	uires that signed b	by	Part II. Other significant condition	ons contributing to dea	th but not resu	lting in the ur	nderlying ca	ause give	n in Part I.						
Records,	9 4 9	Completed			-							rmed?	prior to death?	topsy findings a ompletion of ca	vailable use of
of Vital	ician: Th certificate rector, pag	O O	25. Was case referred to medica	1					26. Place	of Death	1 ☐ Yes (Check only o		1 LJ Yes	2 🗆 No	
Į <	di is	To B	examiner? 1 □ Yes 2 🛛 No	Hospital: 1 🗷 Inp	atient 2 E	R/Outpatien	t 3 DO	A Othe					☐Other (Spec	rify)	
0 U			27. Manner of Death 1 ☑Natural 5 ☐ Pendir	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28	Bc. Injury Work			28d. Describe h				
Sio	Attanding r death. ector: After by the fune	catic	2 Accident investi	gation			М		es 2 🔲	No					
Division	or At after of Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. Place 0	Injury - At hor , etc. (Specify)	ne, farm, str	eet, factory	, office		1	28f. Location (S City or Tox		Number or Ru	ral Route Numb	er,
	To tha Hospital or At within 24 hours after or To tha Funeral Direct completely filled in by	edical	29a. Certifier 1	ng Physician: To the b Examiner: On the bas and manne	is of examinati	rledge, death on and/or inv	occurred a vestigation,	at the time in my op	e, date an inion, dea	d place, a	and due to the dead at the time, d	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifie	. 1				License							
	4		Harl Har	HAT !	N.D.			4323	7			April	L 10, 2	005	
	2		30. Name and address of person	who completed cause	of death (Item	23а) (Туре,	Print)								
	O .		Paul Armstrong		201 Lat	urel P	ark D	rive	#10	2, L	aurel,	MD 20	707		
:-	Sta Registi		31. Date filed (Month, Day, Year)	PR 1 1 2005	istrar s amnati	ITO	Y. A	race.	8						
	3,0	. 3	А	LK T T 700	San Carrie	rem o	- 6								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 10, April 2005 12:36 AM Doris Jean Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth (Month, Day, Year) May 21, 19 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🗓 F 1927 Virginia 231-20-5440 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h Counts 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, it a Modical Examinar must be notified at 1 1 Yes 2 □ No Director Prince George Laurel 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number 1238 € 20707 U.S.A. Completed by Funeral 501 Main Street #417 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If itam 27 is marked other than "natural", or Itams 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 [X]No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Home maker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Daisy Cook Alonzo W. Whorley ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 31631, Baltimore, Maryland 21207 Barry Davis, Sr. /son other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 5 Department of Important: If any injury or once. Apr 14, 05 Roanoke, Virginia Fair View Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 M00773 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart pallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAL TAMPONADE HOURS Priysician /Medical Due to (or as a consequence of) Examiner HOURS VENTRIEVER Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit The law requires that the death certificate be executed HYDEARDIAL HOURS CUTE Due to (or as a consequence of) Box 68760 COROMARY. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be de þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 12 € Onknown 14PERTENSION Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 2 PNo Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) ģ 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. Within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie NU 18551 > , M.A. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAKOMA FARK, MD. 20912 7610 CARROLL AV. NEIMAT. ND. SAMIR 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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Registrar

ORIGINAL

			For State	State o	f Maryland / De	•		Mental Hyg	giene	
			Registrar 1. Decedent's Name (First, Middle	. (act)		Certificate of	Death		Reg. No.2 0 0 5	1211
	Physici	an	DON K. DOVE	s, Lasi)				2. Date of Dea Month	Day Yeer	3: Time of Death
}	/Medio Examir		4a. Fecility Name (If not institution	n give street and nu	mber)	4b. City. Town.	or Location of Death	April 8	8, 2005 4c. County of Dea	10:48pm M
	Exami	iei	Greater Balti			Towson			Baltimon	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		thplace (State or Foreign ountry)
	Director		223-54-5922	1 <u>√2</u> M 2□ F	71 Y	s. Months Days	Hours Min.	11/18/	1933 VI	RGINIA
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	daryla	ö	,	IMORE	PARKVI					1 ☐ Yes 2 ⊋ No
	the N	rect	10e. Street and Number	THORE	1 AIUI VI	10f. Zip Code			10g. Citizen of What Co	71
	3e or	٥	8301 OAKLEIGH	ROAD		2123	L.		USA	outing :
	death ms 2	nera	11. Marital Status	12. Was Dec	edent Ever in U.S.	13. Was Decedent of I	dispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	
36	n 72 hours after death with the Maryland "naturel", or Items 23e or 28e-f show calcal Exeminationals be notified at	by Funeral Director	1 ☐ Never Married 🎢 Marr 3 ☐ Widowed 4 ☐ Divorced	Armed For		If Yes, specify Cub 1 ☐ Yes 2 🛣 No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	e, etc. HITE
21215-0036	2 hou	ted	15. Decedent	's Education	16a. D	ecedent's Usual Occup	pation		16b. Kind of Business	
215	c	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College ((0)	Give kind of work done fe. DO NOT use retire	during most of work	king		
2	filed withi Hygiene. other then	S	12TH GRADE			CHINIST	,		GENERAL EL	ECTRIC
nd	be filed ital Hygi id other event, I	Be	17. Father's Name (First, Middle,	Last)					Maiden Sumame)	
3	should be ind Mental s marked o	၉	WALDEU DOVE				RUTH R			
Maryland	01 00 00 00		19a. Informant's Name/Relations						r, City or Town, State, 2	
	is 1 and 2 of Health item 27 i		MARGIE DOVE/wif 20a. Method of Disposition	<u>e</u>		O1 OAKLEIG		ALTIMORE Date	E MD 2123 20c. Location - City or	
٥	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State '	crematory`or other pla	· 1		-	
altimore,	그 든 윤 글	li	21. Signatule of Funeral Service		MEIRO C	REMATORY,			CATONSVILL I FUNERAL H	
Ã	permi Depa Impo any ir		Heather	N. Hu	y	8521 LOCH	RAVEN BL	VD. TOW	VSON, MD 2	1286
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the death. Do not each line.	A	1 .	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	septic	Shoc				Onset and Death
	Examiner		, , , , , , , , , , , , , , , , , , , ,	Due to	(or as a consequence of)	iou'a				
		ē	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a sonsouper so of)		•			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	an an rial-tr	Exa	resulting in death) Last	Due to	(or as a consequence of)					
68760,	ficate be executed physician and s the burial-transit	edicai		d						
_	entific ling p		IF FEMALE:						-	
Вох	death certi e attending id for use a	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come of pregnancy irth 2 Fetal death	3 □Ectopic pregnancy	,		23d. Date of del	very Day Year
P.O.		Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno	ant at time of death own	5 ☐ Other (specify) _				,
	law requires that the as been signed by the 2 should be detache	F	Part II. Other significant condition	ns contributing to de	eath but not resulting in the	ne underlying cause giv	en in Part I.	23e. Did tob	bacco use contribute to	the cause of death?
rds	w requires that s been signed I should be det	d by	- Sei	rere 1	I emo j	17515		1 □ Y€	es 2□No 3☑Pro	obabiy 4 Unknown
S	s bee	lete	CA	2 P I)	I			24a. Wasa	n 24b. Were au	topsy findings available
æ	The lav	Completed						autops perform	med? prior to death?	completion of cause of
ita	ian: rtifica stor, p	0	25. Was case referred to medical				26. Place of Deatl			2 □ No
<u>></u>	Physician: this certificatal director, I	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2 ER/Outpa	itient 3 DOA Oth	er: 4 Nursing Ho	me 5 Reside	ence 6 Other (Spec	cify)
0	ng PI		27. Mannar of Death 1 ▶ Natural 5 □ Pending	28a. Date (Mont	of Injury 28b. Tim th, Day Year) Inju				ow injury occurred	
sio	Attending or death, ector: After by the funer	cati	2 Accident investig	ation			Yes 2□No			
$\dot{}$	or At after of Direct in by	Certification;	4 Homicide determi	ned 286. Place	of Injury - At home, farm ng, etc. <i>(Specify)</i>	, street, factory, office		28f. Location (St. City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospitel or Atlanding Physician: The I within 24 hours after death, To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifyin	g Physician: To the	best of my knowledge, d	eath occurred at the tir	ne, date and place,	and due to the ca	ause(s) and manner as	stated.
	the Hi in 24 the Fu pletel	Medical	(Check only 2 Medical E	Examiner: On the ba and man	asis of examination and/oner stated.	r investigation, in my o	pinion, death occurr	ed at the time, da	ate and place, and due	to the cause(s)
	To T To T	Σ	29b. Signature and title of certifier	17.1	OU N	29c. Licens	e number	> 25	9d. Date signed (Month	, Day, Year)
)	16		nery	Jua	an 171) 1)	16126		4/4/6	N ,
6	1,1		30. Name and address of herson v	who completed caus	e of death (Item 23a) (Ty	pe, Print) 670	N.C.	harle	1 5KB	alto Mar
	Sta Registra		31. Date filed (Month, Day, Year)	32. R	egistrav's Signature	Ande)			-	

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			1- For State of Maryland / Department or State of Maryland / Certificate of Maryland / Certificate of Maryland / Department or State of Maryland / Department / D	f Health and Men		12112
			Decedent's Name (First, Middle, Last)		Date of Death	3. Time of Death
	Physic: /Medi		Frederick Robert Dieter			8:45 P M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town	n, or Location of Death		
			Mariner Health Care Ctr. Ca	atonsville	Balt	imore
	Funeral Director		5. Social Security Number 218-28-1311 Usual Residence of Decedent 6. Sex 1 (XIM 2 F 72 Yrs. Ast birthday) If Under 1 Ye Months Da	ys Hours Min. (/	Reg. No. 205 2. Date of Death Month Month Day Year April 7, 2005 4c. County of Death Balti 8. Date of Birth (Month, Day, Year) 9. Birth Cot April 12, 1932 Ma 10g. Citizen of What Cot United St. Specify: 9. Birth Cot St. Specify: 9. Birth Cot Specific Specif	thplace (State or Foreign ountry) aryland
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show te Madical Examiner must be notified at	ctor	10a. State 10b. County 10c. City, Town or Location Maryland Baltimore	Sykesville		10d. Inside City Limits 1 ☐ Yes ¾XNo
	th with the	al Dire	10e. Street and Number 10f. Zip Cod 5170 Stone House Village Ct.	e 21784		-
36	init. Pages 1 and 2 should be filed within 72 hours after death with the Marylan seatment of Health and Mental Hygiene. Certant: If Itam 27 Ia marked other than "natural", or items 23e or 28a-f show njury or other traumatic avant, the Medical Examiner must be notified at 6.	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. If Yes, Sive 1 Never Married 12. Was Decedent Ever in U.S. If Yes, Sive 1 Never Married 13. Was Decedent If Yes, specify Companies of the Second S	of Hispanic Origin? (Specify Luban, Mexican, Puerto Ricar No <i>Specify:</i>		
21215-0036	"natural	leted t	15. Decedent's Education 16a. Decedent's Usual Oc	cupation ne during most of working tired)	16b. Kind of Business	
212	filed within Hygiene. other then ent, Ite M	Somp	Elementary/Secondary (0-12) College (1-4or 5+) IIII- DO NOT use 16. 9 Years Crane Ope		Steel Indu	ıstry
Maryland	2 should be file and Mental Hy Ia marked oth aumatic avant	To Be (17. Father's Name (First, Middle, Last) George Dieter			
	1 and 2 sho Health and tam 27 is my		19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) Mr. Michael Dieter (Nephew) 19b. Mailing Address (<i>Str</i>) 5170 Stone	et and Number or Rural Ros House Village	ute Number, City or Town, State, e Ct. Sykesvil:	Zip Code) le, MD 21784
Baltimore,	permit. Pages 1 and Department of Health Important; If Itam 27 any njury or other tr 9000.		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 1Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other) Holly Hill Mem.	olace)	*******	
Balti	permit. Departn Imports any nji			dress of Facility CK Funeral Hor	me of Dundalk, :	Inc. 21222
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of a shock, or beart failure. List only one cause on each line. Immediate Cause (Final disease or condition a			Approximate Interval Between Onset and Death 2 weeks
	Examiner	lical Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cerebro Váscular Accidente de consequence of): Due to (or as a consequence of): Cerebro Váscular Accidente de consequence of): d.		t hemiporesis	Years Years
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify,			livery Day Year
rds, P.	w requires that been signed t should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause Hyper-tengton, Osteopera 4.3, Present	,		
Il Records,	The law requirate has been page 2 should	Completed	Degenerative Joint disease		autopsy prior to performed? performed?	utopsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death Che		
of	Phys this ral dii	tion; To	27. Manney of Death Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Ir			cify)
Division	To tha Hospital or Attanding within 24 hours after death. To tha Funarel Diractor: After completely filled in by the fune.	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. L.	ocation (Street and Number or Ru City or Town, State)	ural Route Number,
	To tha Hospital within 24 hours. To tha Funarel completely filled	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in mand manner stated.	time, date and place, and do y opinion, death occurred at	ue to the cause(s) and manner as the time, date and place, and due	s stated. to the cause(s)
	Vithin vithin Comp	E		ense number 5-25-44		
	34		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin S. Lee, M.D., 100 George Rd #	204, Cator	isville, mi) :	21228
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 1145 AM Decento 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Samurikan Baltimare Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Mondy, Dayo 30ar) Funeral Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 217-24-4740 1 M 2 YF Mary Tand Yrs Director Usual Residence of Decedent Pages 1 and 2 should ba filed within 72 hours after death with tha Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov othar traumatic avent, the Nedical Examinar must be notified at Completed by Funeral Director Mary land Baltimore 1 ☐ Yes 2 ☐ No Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3216 Woodhome Avenue 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cook Kirby's Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis DeFelice ပ Anna Prato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah DeCarlo/Daughter 3216 Woodhome Avenue Parkville Maryland 21234 item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 🔏 Burial 2 🗀 Cremation 3 🗀 Removal from State 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. Moreland Mem. Park 4/13/05 Parkville Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service LicenseeChristina L. Hilton Leonard Address Factive. 5305 Harford Road Baltimore Maryland 21214 hustra 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Endstage Lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical IF FEMALE If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 Other (specify) n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Zunknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 1 🗌 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗀 Yes Certification: To 1 Impatient 2 ER/Outpatient 3 DOA this Manner of Deth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: / the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) tha 29c. License number 29b. Signature and title of certifier 0 29d. Date signed (Month, Day, Year) D0059423 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) Hospital But Building # 303 Bulling MID 212 39 Good Sewarthin

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

			For State	State of M		Departme	ent of Health a ate of Death	and Mental	Hygier	e 005	12111.
			Registrar 1. Decedent's Name (First, Middle, L	ast)		Certifica	ale of Dealif	2. Date	Reg. I	No.	3. Time of Death
	Physici		Francis	DiPa	ula			Mont	ו ר	Day Yeer	0
	/Medio Examir		4a. Facility Name (If not institution, g			4b. Ci	ty, Town, or Location of	of Death		6 2005 4c. County of Dea	
	LAGIIII		FRANKLIN SQUARE				ROSEDALE			BALTI	
	Funeral		5. Social Security Number 6.		ge (In yrs. last i	birthday) If Und	der 1 Year If Under		of Birth		rthplace (State or Foreign
	Director			1 Z M 2 □ F	55	Yrs.	ns Days Hours	Min. NOV.	of Birth h, Day, Yea 16,	1/949 M	laryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c City To	own or Location					101 1-11 01 11 1
	farylians is sho	ō	Maryland Baltimor	° e	Baltir						10d. Inside City Limits 1 ☐ Yes 2 No
	with the Maryland to or 28a-f show	ect	10e. Street and Number		Daron		Zip Code	-	100.0	Citizen of What C	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, the Medical Exant are must be inclined at once.	Completed by Funeral Director	7906 Marfield Place	Apt. K		701.	21236		_	nited St	
	death ms 2	Jera	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was De	cedent of Hispanic Ori Decify Cuban, Mexican	gin? (Specify Yes		14. Race - Am	erican Indian,
\sim ω	after or Ite	Ē	1 XNever Married 2 Married	Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:	No	If Yes, s	V		.)	Black, Whi	ite, etc.
FRANCIS 21215-0036	ural',	d b	3 Widowed 4 Divorced	Year or Dates:						Specify: W	hite
Z P	n 72 h "natu	lete	15. Decedent's (Specify only highest g	Education rade completed)	16	Sa. Decedent's Us (Give kind of	sual Occupation work done during mos use retired)	t of working	16b.	Kind of Business	/Industry
12	withir ane. than	mp	Elementary/Secondary (0-12)	College (1-4or	5+)					Λ	
1 S	filed Hygid other ant,	ပိ	12 yrs. 17. Father's Name (First, Middle, Las	it)		Man	ager	er's Name (First, M	iddle Maid	ACCOUN	ting
an _	ld be ental kad o	To Be		Di Paula				rgaret	Conr		
Jan S	shoul nd M	-	19a. Informant's Name/Relationship		19	9b. Mailing Addre	ess (Street and Numbe				Zip Code)
Di PAULIA , FRANCIS Baltimore, Maryland 21215-0036	nd 2 alth a 27 is		Mr. Daniel S. Di	Paula -Cous			eezewood (ock, MD	
i F	ss 1 a of Hear itam		20a. Method of Disposition	7-	20b. Place	of Disposition (A tery, crematory o		Date		Location - City or	
	Page nent c ant: If		1 X Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec	□Removal from State ify)			aith Cem. (04/12/200	5 Ba	ltimore,	, Maryland
<u>a</u>	permit. Departrimports Imports any inju		21. Signature of Funeral Service Lice	Michael I	F Canapr	22. Name	and Address of Facilit	у	530	5 Harfor	d Rd.
	89 = 89		Mille Cy.	/ Tirchaet I	L. Carrapt	Leo	nard J. Ru	ck, Inc.	Bal	timore,	MD 21214
			23a. Part1. Enter the disease, or con shock, or heart failure. List ont	nplications that caused y one cause on each li	d the death. De	o not enter the m	ode of dying, such as	cardiac or respirate	ory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CARDIO	· Pulmo	NARY A	AREST				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):	,				
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	led sit	ulne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequenc	eror): /					
	eath certificate be executed attending physician and for use as the burial-transit	Examlner	that initiated events resulting in death) Last	cDue to (or as	a consequence	e of):					
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68	ificati g phy as the			u							
Вох	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth	of pregnancy	4b 0 0 5 - 4 i-				23d. Date of de	livery
	at the death by the atter tached for t	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at		th 3 □Ectopic 5 □ Other (Month	Day Year
P. 0	at the by the	hy	9 Unknown	9□ Unknown							
	res that igned to be det	by	Part II. Other significant conditions	contributing to death b	ut not resulting	in the underlying	cause given in Part I.				the cause of death?
ord	w require been sig should b	Completed					····································		I □ Yes	2 □ No 3 □ Pr	robably 4 Unknown
ec	has by	ple			<u>_</u>				Mas an autopsy	24b. Were au	utopsy findings available completion of cause of
<u>=</u>	The l	Co						1 🗆 Y	erformed?	death?	2 No
Vita	nysician: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Check o	nly one)		
jo	sir dil	2	1 Yes 2 No 27. Manner of Death	1 Inpatie	ent 2 KER/C			rsing Home 5 🗆 I			cify)
no	ding F h. After funera	tlon	1 XNatural 5 ☐ Pending	(Month, Da)	y Year)	Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ N		ibe now inj	ury occurred	
Division of Vital Records,	Atten deat ctor: y the	Certification:	3 ☐ Suicide 6 ☐ Could not	28e. Place of Inju	ury - At home,		L		on (Street a	and Number or Ru	ural Route Number.
ρi	after after Dira	erti	4 Homicide	building, etc	c. (Specity)	,	.,,	City o	Town, Sta	te)	
	hours hours meral		29a. Certifier 1 Certifying P	hysician: To the best	of my knowledg	ge, death occurre	d at the time, date and	d place, and due to	the cause(s) and manner as	stated.
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: Attent completely filled in by the funeral	edical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	f examination a	and/or investigation	on, in my opinion, deat	h occurred at the ti	me, date a	nd place, and due	to the cause(s)
	To the To the comp	Σ	29b. Signature and title of certain	1 10	11	() 2	9c. License number		29d. D	ate signed (Monti	h, Day, Year)
			Tra	u word,	100	0.	D52061		Ĺ	+-6-3	2005
1	15		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type, Print)	20 14				
	-		Dr. JOHN WALL,	4000 FRA	NKLIH	SHUARE	- PRIVE	BALTIMO	RE,	MD 212	-57
	Stat Registra	100	31. Date filed (Month, Day, Year) APR 1 1 2	9000 FRA	ai s signature	Speaker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amen ditem#5, per Fn, 6843,5/3/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4a. Facility Name (If not institution, give street and number) April 2005 4:00a /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 6905 Spring Hill Drive Sykesville Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Yrs. Director Dec 1 Va Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits itam 27 is markad othar than "natural", or itams 23a or 28a-f show othar traumatic event, the Madical Examinar must be notified at Md Carroll Sykesville Director 1 ☐ Yes 2 ▼ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6905 Spring Hill Drive 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white þ 3 □Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pagas 1 and 2 should be filad within Deportment of Haalih and Mantal Hygiana. Important: If itam 27 Is marked other than any injury or other treumatic event. The Me Elementary/Secondary (0-12) College (1-4or 5+) hospital administrator health care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Albert Gowans Edith Duckworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald A. Easton (son) 6905 Spring Hill Dr., Sykesville, Md 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 4-7-05 Elkridge, Md 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Fuperal Service Licensee P.O. Box 195 Sykesville, Md 21784 IUN 23a. Part1. Enter the disease, or complications that clusted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Can do Physician pula house /Medical Due to (or as a consequence of): **Examiner** Corsola Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s tha burial-transit The law requires that the death certificate be executed (Osu -Division of Vital Records, P.O. Box 68760. Physician/Medical 38 attanding IF FEMALE: for usa a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this cartificata has autopsy 1 Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referre medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Thesidence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? eath 28b. Time of 27. Mannel Aftar Injury 5 Pending atural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of r knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of e and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 28246 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles E. Sheehan, M.D. 10298-B Baltimore Nat'l Pike, Ellicott City, Md 21042 31. Date filed (Month, Pay, Year) 32. Registrar's Signature State Registrar

Stephen Emery 05-2293 DOS

449	3		For State Registrar	State of M	arylar	-	artment o			nd Me		jiene	005	121	16
	Physici /Medio		1. Decedent's Name (First, Middle Stephen Emery	*			-				Date of Dea Month	th Day	Year 05	3. Time of Dea	ath M
	Examir		4a. Facility Name (If not institution Peninsula Reg	ional Medica	al Ce		4b. City, To	bury		Death		4c. Cou	nty of Death	1777	P
	Funeral Director		5. Social Security Number 215-11-0514 Usual Residence of Decedent	6. Sex 7. Ag 1 ☑ M 2 ☐ F	le (In yrs. 21	last birthday) Yrs.	If Under 1 \ Months D		f Under 2 Hours	Min. 8	Date of Birth (Month, Day Aug 23	1983	Year Year 2005 County of Death COMICO 9 Birthplace Country? Mary1. 10d. In 11 11 12 10d. In 11 11 12 11 12 13 14 15 15 16 16 17 17 17 18 18 18 19 19 19 19 19 19 19	place (State or Fo ntry) Tyland	reign
	death with the Maryland ms 23a or 28e-f show LTUSI be notified at	ctor	MD 10b. County Cecil			ty, Town or Lo North		,						10d. Inside City Li 1 ☐ Yes 25	
	ath with the 23a or 28 ust be not	al Director	10e. Street and Number 1212 Calvert R	oad			10f. Zip Co	de 21901	1					ntry?	
920	urs after al', or Ita Evarrire	by Funeral	11. Marital Status 1 ⅔ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Vas Giva			Was Deceden f Yes, specify 1 ☐ Yes 2X		anic Orig Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- can, etc.)	8	Black, White,	etc.	
Maryland 21215-0036	- 4 32	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12) 12	t's Education at grade completed) College (1-4or :	5+)	(Give	dent's Usual C kind of work o DO NDT use r	lone duri	on ing most	of working	unk	16b. Kind of	f Business/In	dustry	unk
yland 2	2 should be filed withir and Mental Hygiene. Is marked othar then aumetic evant, Ire M.	To Be C	17. Father's Name (First, Middle, Charles C. I	Emery					Bar	bara	First, Middle,	ner			
re, Mar	ges 1 and 2 should it of Health and Men if item 27 is marke or other traumetic		19a. Informant's Name/Relations Charles C. Emer 20a. Method of Disposition	y/father	20b. F	1212 Place of Dispo	Calve	rt R			East,	MD :	21901		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or other tra <u>2005</u> 8.		1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S 21. Signatur of Funeral 3- vice	pecify)	1	emetery, crem			of Facility	oard (655 W.	Balti	more S	Street	
	Physician		23a. Part Lenter the disease, or shock or heart failure. List Immediate Cause (Final	complications that caused only one cause on each li	the deat	h. Do not ent	er the mode o	e, M	and as co	ardiac or r	espiratory arr	est,		Approximate Interval Between Onset and Deat	n h
	/Medical Examiner	Examiner	disease or condition resulting in death) Sequentially list conditions. If any, leading to introduct cause. Enter Underlying Cause, (Disease or injury	a. Conto Due to (or as	a conseq	uence of):	0, 100	0(1)	pue	ing	unes				
,0928	death certificate be executed e attending physician and of for use as the burial-transit	dical	that initiated events resulting in death) Last	cDue to (or as	a conseq	uence of):									
P.O. Box 6	the che	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3	Ectopic pregr Other (s <i>pecil</i>							,	
	The law requires that ate has been signed b page 2 should be deta	by	Part II. Other significant condition	ns contributing to death b	ut not res	ulting in the ur	nderlying caus	e given ii	n Part I.		23e. Did tol	3.7		ne cause of death	
al Records,	iician: The law re certificate has ber rector, page 2 sho	Completed									24a. Was a autops perform	Y	prior to cor	psy findings avail mpletion of cause 2 No	able of
Division of Vital	ding Phys n. After this funeral di	Certification: To Be	25. Was case referred to medical examiner? 12 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investig 2 Accident 6 Could determ	Hospital: 1 1 Inpatie 28a. Date of inju (Month, Da not be ined 28e. Place of inju building, et	ry y Year) 2005 ury - At ho	ome, farm, stre	28c. A ^M eet, factory, of	Other: Injury at Work? 1 Yes	4 🗌 Nurs	sing Home 286 5 0	Location (St City or Town	ence 6 00 ow injury occ the control occurs reet and Nur r, State)	mber or lura	by	
	To tha Hospital or Attent within 24 hours after death To tha Funaral Diractor: completely filled in by the	Medical C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best Examiner: On the basis of and manner sta	of my kno f examina	wledge, death tion and/or inv	occurred at the	ne time, o	date and on, death	place, and	8 22 N I due to the ca at the time, da	ause(s) and	manner as si	tated. the cause(s))
	To the within To the comp	¥	29b. Signature and title of certifier	3 Green	2	No		cense nu	umber						
				Greenber	91	1.D.	111 1	Penn	Stre	eet	Baltim	ore, N	Maryla	nd 21201	
	Sta Registr	1 2	31. Date filed (Month, Day, Year) APR 1 1 20	32. Registr	ar 9 cigna	ilure de la companya									

			For State Registrar	State of Ma	-	artment of Health and rtificate of Death	-	ene 0 0 5	12117
	Physici /Medic		1. Decedent's Name (First, Middle, Las Abdu V Va Za	y Ibn	Fisher		2. Date of Death Month	Day Year 95	3. Time of Death 13:25 PM
	Examir		4a. Facility Name (If not institution, give Me CV)	O Cente		4b. City, Town, or Location of Dea		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Se	X 7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		(ear) 9. Birthy Cou.	place (State or Foreign ntry) ARYLAND
	r 26e-f ehow	ţō	10a. State 10b. County	1/2	10c. City, Town or Lo	N	ORE C	7174	10d. Inside City Limits 1⊈Yes 2 □ No
	deeth with the Meryland me 23a or 28e-f ehow rmust te notified at	Funeral Director	10e. Street and Number	RIDGE	T. ADTA	10f. Zip Code 2 / 2	100	g. Citizen of What Cou.	
5-0036	or its	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Er Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puel		14. Race - Americ Black, White,	can Indian,
21215-0	be filed within 72 hours tei Hygiene. d othar then "neturel", event, the Madical Ex	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) NOT use retired)	orking 16	Sib. Kind of Business/In	dustry
Maryland	A P T O	To Be C	17. Father's Name (First, Middle, Last) TELLEV		FISHE		me (First, Middle, Ma SEEVA	. /	RIM
Baitlmore, Mary	ges 1 end 2 t of Heeith e if Item 27 le or other treu		19a. Informant's Name/Retionship (7 TELLEY FISHER 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation □ □ Other (Specify	(FATHE) Removal from State	20b. Place of Dispo	natory or other place)	E CT. A47		MD 2/229 own, State
Bait	permit. Pa Department importent: any injury		21. Signature of Funeral Service Library 23a. Part1. Enter the disease, or comp	1 Bm	22	Name and Addr ss of Facility JOSEPH HT. JUSEPH FULT	BROWN.	JR, FUNE BALTO, F	RAL HOME
3760,	/Medical Examiner parisher be executed by signer and the parish that the paris	dical Examiner	shock, or heart failure. List only of the shock of heart failure. List only of the shock of the	Due to (or as a b. Due to (or as a c.	Consequence of): Consequence of): Consequence of): Extreme consequence of):	my hypertensis emal Prematurita	7		Interval Between Onset and Death
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	requires thet the	ል	Part II, Other significant conditions on Sever-e	Nentributing to death but		nderlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to the	ne cause of death?
I Records,	The lev ete hes pege 2	Completed	- Perivent	riular	echo deh	847	24a. Was an autopsy performe	d? death?	psy findings available mpletion of cause of 2 No
Vita	Physicien: Th this certificate rei director, per	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 25€No	Hospital:	t 2 ER/Outpatier	Other	ath (Check only one)	ce 6 □Other (Specif	v)
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Divis	s efter dee bi Diractor ed in by the	Sertifica	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	i Route Number,
	To the Hospital or Attending Physicien: within 24 hours elter deeth. To the Funerel Director: After this certific completely illied in by the funerel director,	Medical Certification;	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of e and manner state	xamination and/or in	occurred at the time, date and place vestigation, in my opinion, death occurred	e, and due to the cau urred at the time, date	se(s) and manner as s a and place, and due to	ated. the cause(s)
	Tot Tot		29b. Signature and title of certifier	Fillint	MD	29c. License number D 6 2150		Date signed (Month, 48 05	Day, Year)
	\		30. Name and address of person who of Fev name	ompleted cause of dea	ath (Item 23a) (Type,	301 St Paul 7	Place Be	1tmore	MD 21202
w	Sta Registr	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature			7	

			For	State of Ma		partment of Hea		ntal Hygien	ie	
			1 - State Registrar		C	ertificate of De	eath	Reg. N	2005	12118
	Physici	an	1. Decedent's Name (First, Middle, Last				2	2. Date of Death Month D	ay Year	3. Time of Death
	/Medi			Lacy Da	llas Fit	zgerald			2005	3:00 A M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	cation of Death	4	c. County of Death	
			1922 Haselmere R	oad		Dunda:			Baltim	ore
	Funeral		5. Social Security Number 6. Se	x 7. Ag] M 2 ☐ F	e (In yrs. last birthda		Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Yea	r) 9. Birthp	place (State or Foreign
	Director		236-30-9897	1141 207	78 Yrs.			April 27	,1926 Wes	t ["] Virginia
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	sho	5		imore	,,	200411011	Dundalk			1 ☐ Yes 2 🔀 No
	the N	ect	10e. Street and Number			Lot 7: O. I.	Dundan			
	with e or	급				10f. Zip Code			Citizen of What Cour	
	eath	era	1922 Haselmere	ROACI 12. Was Decedent	Ever in H.S. 1		21222		nited Sta	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23e or 28a-1 show other treumstic event. Its Medical Evant and must be restlifted at	by Funeral Director	1 ☐ Never Married 2€XMarried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 17 X Yes 2 1 1 If Yes, Give Year or Dates:	No	 Was Decedent of Hispa If Yes, specify Cuban, N 1 ☐ Yes 2 No S 	Mexican, Puerto Ric Specify:	can, etc.)	14. Race - Americ Black, White, Specify:	etc.
þ	ture ture	ed	15. Decedent's Edu			cedent's Usual Occupation	n	165	Kind of Business/In-	White
15	n "ne	Completed	(Specify only highest grad	e completed)	(Gi	ve kind of work done durir DO NOT use retired)	ng most of working	100.	Kind of Businessylli	udstry
212	with with the second	E	Elementary/Secondary (0-12) 10 Years	College (1-4or 5	,	Mechanic			Steel Ind	nstry
	filled I Hyg othe	0	17. Father's Name (First, Middle, Last)				. Mother's Name (F	First, Middle, Maide		abery
Maryland	2 should be filed within and Mental Hygiene. Fis marked other than "reumatic event, the Mental Mental Commental Comment	To B	Dan Lansford	Fitzerald			Sally A	nnie Jone	es	
ary	shou ind N ind N		19a. Informant's Name/Relationship (Ty	rpe, Print) Wife	19b. Ma	iling Address (Street and	Number or Rural F	Route Number, City	or Town, State, Zip	Code)
	Health a Health a tem 27 is		Mrs. Virginia P	. Fitzger	ald 1	922 Ha sel men	re Road	Dundalk,	Maryland	21222
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other place)	Date	e 20c.	Location - City or To	wn, State
Ë	Pages nent of H ant: If ite ary or of		XXBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State		11 Mem. Gdns	s. 4/11/	2005	Middle Ri	ver. MD
äĦ	mit. Dartm Dorte rinju		21. Signature of Funeral Service Licens	99 60	the second secon	22. Name and Address of	f Facility			
m	Department		To phance	11b	sey	Duda-Ruck 7922 Wise				nc. 21222
			23a. Part1. Enter he disease, or compl	ications that caused	the death. So hot e				- Julia 2	Approximate
	Pnysician		shock, or heart failure. List only or Immediate Cause (Final	Te cause on each in	1 - L \	C-1-	/	. =		Interval Between Onset and Death
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V	orted ansit	Examiner	Cause (Disease or injury that initiated events							
ó	an ar rial-tı		resulting in death) Last	Due to (or as	a consequence of):					
68760,	icate be executed physician and s the burial-transit	edical		d						
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ŏ	death certifi e attending p ed for use as	Physician/M	23b. Was decedent pregnant	3c. If yes, outcome 1☐Live birth		☐Ectopic pregnancy		Į	23d. Date of delive	ry
B.	0 0 0	sicia	in the past 12 months? 1 Pyes 2 No	4□Pregnant at		Other (specify)			Month	Day Year
P.0	at the de by the stached	hy	9 🗆 Unknown							
	The law requires that the te has been signed by the hage 2 should be detache	by F	Part II. Other significant conditions cor	tributing to death bu	ut not resulting in the	underlying cause given in	n Part I.		use contribute to th	e cause of death?
ord	w require been si should I							1 ☐ Yes 2	2 TMo 3 □ Prob	ably 4 □Unknown
Vital Records,	law r as be 2 sh	Completed						24a. Was an autopsy	24b. Were autop	psy findings available appletion of cause of
R		Om						performed? 1☐ Yes 2☐N	✓ death?	
ita/	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			26	. Place of Death (C			
of V	d is	10	1 ☐ Yes 2 ☑ No	lospital: 1 ☐ Inpatie	nt 2 ER/Outpati	ent 3 DOA Other:	4 Nursing Home	5 Residence	6 ☐Other (Specify)
	ding Ph h. After th funeral	:uo	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time		280	d. Describe how inju	ury occurred	
0.5	Attending in death.	ati	2 Accident investigation				2 No			
Division	after death after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury · At home, farm, : c. (Specify)	street, factory, office	28f	Location (Street a City or Town, Stat	nd Number or Rural te)	Route Number,
	rel c			ł)						
	To the Hospitel (within 24 hours all To the Funerel D completely filled i	edical	(Check only 2 Medical Examin	ner: On the basis of	examination and/or	ath occurred at the time, d investigation, in my opinio	late and place, and on, death occurred	due to the cause(s	s) and manner as stand place, and due to	ated. The cause(s)
	To the Hos within 24 ho To the Fun completely f	Med	onej	and manner sta	eted.					
	T wit		29b. Signature and title of certifier	M.	a.	29c. License nui		29d. Da	ate signed (Month, L	
7						245	370	1108	TI T, EL	705
	10+1		Name and address of person who co	expleted cause of de	eath (Item 23a) (Type	er Circle#	211 R	ماما من سم	MA	21236
			31. Data illed (Month, Day, Year)	32 Pagieter	ar's Signature	. arcen	211/00	an mar	ر ت	21236
*:	Sta Registr		ΔPR 1 1 2	005	M M	dracks				

amend Please Type of Print in Plack Indatible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jerry Green 05 4:15 P M 2005 April /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sinai Hospital **Baltimore** N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

July 8, 1947 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1€ M 2□F 25 **214-04-0508** 57 Director Maryland Usual Residence of Decedent death with the Maryland works 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or itema 23a or 28a-f shov traumatic event, <u>tre Madical Examinar must be notified al</u> Maryland N/A XXYes 2□No Baltimore Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2531 Boarman Avenue 21215 USA 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 🖾 🗗 vorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Construction Work 9th grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumatic event ODEs. 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Sumame) Kenley Green ပ Luco Lucille Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha Bowens/ Sister 4017 Bateman Ave Baltimore, Maryland 21216
ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 4/13/05 Baltimore, Maryland ^{22. Name and Address of Facility}Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21 21. Signature of Juneral Service Ligentsee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cormary artery thrombosi's **Physician** /Medical **Examiner** perflusive atheroschootic Cardiovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Phyaician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

✓ Yes 2 □ No 2□ No 1X Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Inpatient 2 EP/Outpatient 3 DOA ို 1X Yes 2 □ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral 6 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME April 06, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 1 2005

32 Aegistrar's Signature

Registrar

APR 1 1 2005

			1 - For State Registrer	State of Mar		artment of He			000	5 1210		
	Physic		Decedent's Name (First, Middle, Last, E		NED			2. Date of Death Month APRIL	Day Yo			
	/Medi Examii		4a. Facility Name (If not institution, give FREDERICK MEMO	street and number)		4b. City, Town, or L		APKIL	4c. County of I	Death		
	Funeral Director		5. Social Security Number 6. Set 218-20-7813	ייי פרוב	(In yrs. last birthday) 8 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar 27,	And Day Year 2 , 2005 4c. County of De FREDER The Year) 9. B. County of De FREDER The Year) 1927 M. 10g. Citizen of What County of What County of What County of What County of Manager Specify: 16b. Kind of Busines Maiden Sumame) Maiden Sumame) Maiden Sumame) Maiden Sumame 17, City or Town, State, Double of death? 21771 20c. Location - City of County of Manager Specify: 23d. Date of death? 21771 20c. Location - City of County of Manager Specify: 10 24b. Were a prior to death? 21771 20c. Location - City of Manager Specify: 10 24b. Were a specify: 11 Yes 12 24b. Were a specify: 23d. Date of death? 24d. Were a specify: 24d. Date of death? 25d. Date of death? 26d. Date signed (Monager Specify): 27d. Date signed (Monager Speci	Birthplace (State or Foreign Country) Maryland		
	ath with the Maryland 23e or 28e-f show ust be notified at	Director	10a. State MD 10b. County Frederic		Oc. City, Town or Lo	ederick				10d. Inside City Limits 1 ☐ Yes 2X☐ No		
9	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show after Examirer: wat be rutified at	Funeral	10e. Street and Number 355 Montevue Lane 11. Marital Status unk 1 □ Never Married 2 □ Married	12. Was Decedent Ev Armed Forces? 1 XYes 2 □ No		10f. Zip Code 217 Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto		USA 14. Race -	American Indian, White, etc.		
Maryland 21215-0036	d within 72 hours giene. ir than "naturel", Ir e Modical Exp	Completed by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) unk un	completed) College (1-4or 5+)	16a. Decec (Give	1 □ Yes 2 No dent's Usual Occupation kind of work done dure DO NOT use retired)	Specify: on on most of working most of working	unk 16		white ess/Industry unk		
yland ;	should be filed ind Mental Hygi s marked other umetic avent, II	To Be C	17. Father's Name (First, Middle, Last) Edward Harris G				Lottie	Ewing				
re, Mar	1 and 2 Health a em 27 is ther tre	1 1	19a. Informant's Name/Relationship (Ty, Judy Gouge/friend 20a. Method of Disposition	pe, Print)	4500 20b. Place of Dispo	Buffalo Ro	oad Mt. A	Airy, MD	21771			
Baltimore,	permit. Pages Department of I Importent: If It any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☒ Donation 5 ☐ Other (Specify) 21. St nature of Funeral Service License Ronal		1	natory or other place) . Name and Address	of Facility					
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	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c		no carcinom	19			Onset and Death		
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P.O. Box 68	The law requires that the death certifica tie has been signed by the atlending ph page 2 should be detached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	∃Fetal death 3 🗆	Ectopic pregnancy Other (specify)			la l	delivery Day Year		
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al Reco	ysicien: The law ru is certilicate has be director, page 2 sh	Completed						24a. Was an autopsy performe	d? prior deat			
Division of Vital Record	To the Hospitel or Attending Physicien: which 24 hours alter deals as alter deals. To the Funerel Director: After this certifics completely tilled in by the tuneral director;	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatient 28b. Time of Injury	28c. Injury at Work?	4 ☐ Nursing Hom			Specify)		
Divis	spitel or Atte ours after dec nerel Directo tilled in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (Specify)			City or Town, S	State)			
	To the Hospitel within 24 hours To the Funerel completely tilled	Medical	one)	ician: To the best of ner: On the basis of ex and manner stated	amination and/or inv	estigation, in my opini	on, death occurre	d at the time, date	and place, and	due to the cause(s)		
	To wit	-	29b. Signature and title of certifier) .			55793	29d.				
			30. Name and address of person who con SURCSH K	npleted cause of deat	. 1)	Frederick	Memorial	Hospita				
H	Sta Registr	-	APR 1 1 2005	Casus A	John			norial Hospital				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** PH Howe /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Facility Name (If not institution, give street and number) Examiner Sandbull BAHO, MO If Under 1 Year If Under 24 Hrs. 8. Date of Birth Min. Month, Day, Year 6. Sex 180 M 2□ F 7. Age (In yrs. lest birthdey) 8. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Usual Residence of Decedent Yrs. Director death with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shot treumstic event, the Medical Examinar mast be notified at 4- Yes 2□No Director 10g, Citizen of What Country? 10e. Street end Number 2121 USA by Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 21 No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after or nent of Health end Mentel Hygiene. nnt: If item 27 is marked other than "natural", or ite 1 Never Married 2 ☐ Married 1 Yes 20 No Specify: RICER Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) SPARAOUS 621C7 Elementery/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be MOSES ည 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2/2/3 19a. Informant's Name/Relationship (Type, Print) WHITE SISTER COLLENGTON AN 13410 MIL 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CATONSVILLEMO 21. Signature of Funeral Service Licensee Enter the esease, or complications that, or heart ailure. List only one ceuse on eath. Do not enter the mode of dying, such as cardiac or respiretory arrest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner centificata has been signed by the attending physician and lifector, pege 2 should be datached for use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, 10 Be Completed by Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 21ZN0 TL Yes 1 ☐ Yes 2 ☐ No Attending Physician: tor: After this certific the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completaly filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifie Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certifier vn 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

APR 1 1 2005

871N

32. Registrer's Signature

OF CORRESPONDED

ORIGINAL

DHMH 16 Rev 6/95

			. For	State of Mar				of Health		•		egible.	
			For State Registrar			Cer	tificate	of Death	7		Reg. No.	005	12121
П	Physici	an	Decedent's Name (First, Middle,	Last)			4-17	DERSOI		2. Date of Dea	Day	Year_	3. Time of Death
	/Medic	al	PEGGY 4e. Fecility Name (If not institution,	nive street and number)				own, or Location		APRIL		2005 county of Death	15:43 "
	Examin	er	The Tabios Ho	PKins Hosp	it al		B (1)	tim ore	120	F Y	40.0	n/a	a
	Funeral		5. Social Security Number 6	S. Sex 7. Age	(In yrs. last	birthday)	If Under 1	Year If Unde	r 24 Hrs.	8. Date of Birt (Month, Da)	h Vear		place (State or Foreign ntry)
L	Director		218 42 0470	1 □ M 2 🔀 F	59	Yrs.	Months	Days Hours	Min.	NOV. 2	19	45 VIRG	INIA
	pue M		Usual Residence of Decedent 10a. State 10b. County	11	10c. City, T	own or Lo	cation					1.	10d. Inside City Limits
	Manyl f sho	ក្ន	MD		BALTIN								1 XYes 2 □ No
	r 286	Director	MD 10e. Street and Number	IV/A	ארדיד דר.	ONE	10f. Zip C	Code			10g. Citize	en of What Cou	ntry?
	th with		2400 E. LAFAYETT	TE AVE.			21213	3			U.S	.A.	
	r dea	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. \	Was Decede f Yes, specif	nt of Hispanic O y Cuban, Mexica	rigin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)	. 14	Race - Ameri Black, White,	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			1⊡Yes 2∯					Specify: DT	NOV.
21215-0036	d within 72 hours after death with the Marylend piene. r then "neturel", or Itams 23a or 28e-f show the Medicel Eraminer must be notified at		15. Decedent's	Education	1	6a. Deced	dent's Usual	Occupation			16b. Kind	DL d of Business/In	ACK dustry
215	within 73 ene. than "n	pie	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+))	(Give life. L	kind of work DO NOT use	done during mo retired)	st of work	ng			
	filed wil Hygien other tha	Completed	llth			CASHI	ER					MARK PA	RKING
and	be de la se	Be	17. Father's Name (First, Middle, La LEE HENDERSON SE							(First, Middle,		umame)	
Maryland	should nd Mer marke marke	၉	19a. Informant's Name/Relationship			10h Mailin	a Address /	Street and Number		AE HAREI		Town State 7in	Code)
Ma	s 1 and 2 should if Health and Mer item 27 is marke other traumatic	8 3	JESSIE MAE HENDE					FAYETTE					
re,	of Heal	1 8	20a. Method of Disposition		20b. Place	e of Dispo	sition (Name	e of	C	Pate	20c. Loca	ation - City or To	own, State
Baltimore,	permit. Pages Department of I Importent: If Its any injury or of		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Denation 5 ☐ Other (Special Control C		1	ZION	CEMETI	ERY /					, MARYLAND
3alt	Departition Departition Departition Departition Departition Departition Department of the Department o		21 Aurature of Funeral Service Li	censee									ERAL HOME
	& O = € d		Muade	e Mar	ugg	Co. I show						E, MARY	LAND 21213
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	nry one cause on each line				of dying, such a	is cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. LIVER			E						6 YEARS
	Examiner			Due to (or as a LACTIC	á.	ice or):	515						2 DAYS
4		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequen	ice of):	-	tro-Are-Stelland		and Per			_
V	rcuted nd transil	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· SPONT			BACT	ERIAL	TER	PITONI	TIS		7 DAYS
760,	ite be executed lysician and ne burial-transit		resulting in death) Last	Due to (or as a	consequen	ice of):							
687	\$ ≥ 5	edicai	.	d									
×6	death certifics e attending ph id for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23	d. Date of deliv	erv
. Box	death e atte	Physician/M	in the past 12 months?	1□Live birth 2 4□Pregnant at tir			Ectopic pred Other <i>(spec</i>					Month	Day Year
P.O.		hys	9 🗆 Unknown	9L] Unknown									
Ś	se und	by	Part II. Other significant condition	s contributing to death but	not resultin	ng in the ur	nderlying cau	use given in Part	l.				he cause of death?
Record	v requir been si should	eted											oably 4 □Unknown
3ec	e law has b	Completed								24a. Was autop		24b. Were auto prior to co death?	ppsy findings available impletion of cause of
	iclan: The licertificate ha	1 - r	25. Was case referred to medical							1 ☐ Yes	2 🛭 No	1 ☐ Yes	2 ⊠ No
of Vital	Physiclan: this certificated director,	To Be	examiner?	Hospital:	2 🗆 EB	/Outnation	1 3 DOA	Othor		n <i>(Check only o</i> me 5 ☐ Resid		Other (Special	f _V)
	ding Phy h. After this funeral c		27. Manner of Death	28a. Date of Injury (Month, Day)		b. Time of		c. Injury at Work?		28d. Describe h			<i>y</i> /
Sior	i a i	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	, 62.7	прату	М	1 Yes 2	□No				
Division	or Attenuation death	Certification:	3 Suicide 6 Could no 4 Homicide determin		y - At home (Specify)	, farm, str	eet, factory,	office		28f. Location (S City or Tow		Number or Rura	al Route Number,
	pital ours al		29a. Certifier 1 Certifying	Physician: To the best of	my knowlo	dan dant		t the time date a	and place	and due to the	22160(0) 0	nd manner of of	tatad
	To the Hospital or Atter within 24 hours after de To the Funeral Diracto completely filled in by th	dical		xeminer: On the basis of e	xamination								
	To th within To th compl	Me	29b. Signature and title of certifier	0				License number				signed (Month,	
)			· Nicola Totale	D. M.D			1	RESCO	0		APRI	L, 07	, 2005
	10		30. Name and address of person w	ho completed cause of dea	ath (Item 23	Ba) (Type, L干と 〜	Print)	BALTIN	MORE	MARYL	AND	21287	
	Sta	te	31. Date filed (Month, Day, Year)							•			
	Registr		APRI	1 2005	3460)	0. 1	Provide						

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	•	Reg. No.2	n G	12125
			Decedent's Name (First, Middle, Last)	2. Date of De	eth	1/1	3. Time of Death
	Physici /Media		Maurice H. Hellner	Month April	Dey 2	Year 005	9:30am
	Examir		4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Le				J. Joan
			Buckingham's Choice Health Care Center Adamstow	m	Fr	ederio	k
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs.	8. Date of Bir (Month, Da			ce (State or Foreign
	Director		571-12-2215 83 Yrs.		0, 1921		esota
	pu s	•	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			100	f. Inside City Limits
	show	7				100	1. Inside City Limits 1 ☐ Yes 2 No
	ha M	Director	Maryland Frederick Adamstown		40. 02	***	
	di di	Ö	10e. Street end Number 10f. Zip Code		10g. Citizen of \		
	ath 23	Funerai	3200 Baker Circle # 101 21710 11. Maritel Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp		United	States e - Americar	
_	iter d	Š	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Blac	k, White, et	
20	is ef	by	1 Yes 2 No Specify: 3 □ Widowed 4 □ Divorced Year or Dates: 1943-45		Specify	′: W1	nite
21215-0020	2 should be filed within 72 hours efter death with the Marylend end Mentel Hygiene. is marked other than "natural", or items 23a or 28e-f show reumatic event, the Medical Examiner must be notified at	Completed by	15 Decedent's Education 16a Decedent's Usual Occupation		16b. Kind of Be		
215	hin 7	pie	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Deputy Director of	ding .	Defense	Intel	ligence
21	d wit	ĕ	Elementary/Secondary (0-12) College (1-4or 5+) Deputy Director of Data Handleing		Agency		-
	e file othe vent,	Be	17. Father's Name (First, Middle, Lest) 18. Mother's Name	e (First, Middle,	Maiden Sumen	ie)	
Maryland	uld b Vente rked ritc e	ToE	Lars Hellner Mary Rot	hzen			
an	shod head		19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Run	al Route Numb	er, City or Town,	State, Zip C	ode)
	and selth	ij	Artye B. Hellner/ Wife 3134 Periwinkle Court,	Adamst	own, Ma	ryland	21710
ore	r oth		20a. Method of Disposition 1 Burial 2 🗷 Cremation 3 Removal from State)5 Date	20c. Location -	City or Town	n, State
Ē	Peg nent ant: i		4 Donation 5 Other (Specify) Metropolitan Crematorium I		Alexand	ria, V	Virginia
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours efter death with tha Maryler Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Olin L. Molesworth	D A	Funova 1	Hama	
Ш	20 = 20		Jodd Dulyw 26401 Ridge Road,				0872
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	A	pproximate nterval Between
Y	Physician						onset and Death
T.	/Medical Examiner		Immediate Cause (Final disease or condition End Stave Parkinson				
	Examine		resulting in deeth) Due to (or as a consequence of):				
	be is	Examiner	b			i	
_	and and I-trer	xan	Sequentially list conditions, Due to (or as a consequence of): if env. leading to immediate			į.	
9	be e sician burie	a	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as a consequence of): Due to (or as e consequence of):			1	
68760,	rificeta be executed no physician and as the bunel-trensit	Physician/Medical	resulting in death) Last Due to (or as e consequence of):			1	
Box		₹	d			- 1	
Ď	laath cer attandin d for usa	Ca	Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.	22h Did	Inhana una car	etribute to t	ne cause of death?
P.O.	tha c by the achee	hys	Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.	1			bly 4 Unknown
	that ned b	by P	<u>HTIN</u>	"	ies zję no	5 11000	ory 4 direction
ž,	Physician: The law requires that the death cer this certificate hes been signed by the attandir ral director, page 2 should be delached for usa	교			en eutopsy	24b. Were	autopsy findings
ပ္ပ	w rec	Completed		репо	rmed?	comp of de	eletion of cause
æ	he la e hes age 2	E		100	Yes 3 No	101	
<u>ta</u>	hysician: The law nis certificate hes b il director, page 2 s	BeC	25. Was case referred to medical 26. Place of Deat				100 12110
5	s cert	0	examiner?		dence 6 □Oth	er (Specify)	
0	Physer this eral of	닐	27. Menner of Deeth 28a. Date of Injury 28b. Time of 28c. Injury at		now injury occur		
<u>ö</u>	Attending or death. ector: Affer by the fune	ફ	1 Matural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No				
Division of Vital Records,	er de ecto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and Numb	e <i>r or Rural F</i>	Route Number,
Ö	rs efter Bi Dir ed in	9					
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completaly filled in by the funeral	edicai	29a. Certifier (Check only Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred.				
	the the the plant of the	Med	one) and manner stated.				
	5 × 5 0		29b. Signature end title of certifier PARKVIEW MEDICAL GROUP 29c. License number D 00 58 7 2		29d. Date signed		y, rear)
	. 1		30. Name end address of person who comprehenses of dealingthem 23e) (Type, Print)	0	1 0		
	1014		30. Name end address of person who comprehenced a default (literary 23e) (Type, Print) MYERSVILLE, MD 21773				
	· ·	to.	or your volly er.				
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 1 1 2005				

| HAFFER, PAULINE 4.3.05 7 11 年 PM Baltimore, Maryland 21215-0036

			For State		State of	Marylar	nd / Dep		nt of H	Ensure A lealth and I		/giene	200	E 1010
			Registrar 1. Decedent's Name (First, Midd	dle 1 ast)				eruncai	e or i	Death	2. Date of D	Reg. No	. 400	3. Time of Death
Pł	vsicia	ın									Month	Da		ar
	tending Physicien: The law requires that the death certificate be executed beath. By Sold Beath. By Sold Beath and Should be detached for use as the burial-transit. By Sold Beath and Montal Beath and Montal Beath and By the attending physician and burial-transit. By Sold Beath and		Pauline Haffe 4a. Facility Name (If not institution		reet and numb	oer)		4b. City.	Town, or	Location of Death	April	3, 4c	2005 County of D	7:14 PM "
	Kallilli	31	Gilchrist Cent				are			Towson		В.	altimo	T 0
Fur	neral		5. Social Security Number	6. Sex	7		last birthday) If Under	r 1 Year	If Under 24 Hrs. Hours Min.	8. Date of B	irth		Birthplace (State or Foreig Country)
Dire	ector	ļ	217-34-4934	1 📙	M 2 26	66	Yrs.	IVIOITIIS	Days	TIOUIS IVIAI.	06/04			oounity)
pug 3	-000	-	Usual Residence of Decedent 10a. State 10b. Count	v		10c. C	ity, Town or I	ocation						10d. Inside City Limit
Manyl	a Da	ō												1 □ Yes S□N
the t	High High	Funeral Director	MD Balt: 10e. Street and Number	ımore	<u> </u>	Ro	sedale	10f. Zip	Code			10g. Cit	izen of What	
with 3e or	34		2 Clemtine Ct.						237			IIni	ted St	2+05
death	T T	nera	11. Marital Status	1	2. Was Deced Armed Ford	ent Ever in U	J.S. 13			ispanic Origin? (S an, Mexican, Puert	pecify Yes or N		14. Race - A	merican Indian,
after c	1	Ī	1 Never Married 2 Ma	rried	1 Tes 2	NO		1 ☐ Yes		in, Mexican, Puero	o Hican, etc.)			/hite, etc.
Sours .	Exa	d by	3 Widowed 4 □ Divorce	d	Year or Dat	es:							Specify: Wh	nite
721	Ziliya Ziliya	ete	15. Decede (Specify only high	nt's Educ es <i>t gr</i> a <i>d</i> e	ation <i>completed)</i>		(Giv	edent's Usua e kind of wa	rk done d	during most of wor	king		ind of Busine	ess/Industry
od within 72 hours afregiene.	M N	Completed	Elementary/Secondary (0-12)		College (1-4	lor 5+)		<i>DO NOT</i> u	20 1011100	")		Own	Home	
Hygir	ent. I		8 17. Father's Name (First, Middle	, Last)			Home	maker		18. Mother's Nan	ne (First, Middle	e, Maiden	Sumame)	
ld be ental	ic ev	To Be	Unknown Unkno	wn						Virginia	Door			
d 2 should be file the and Mental Hy	пша	_	19a. Informant's Name/Relation	ship (Typ	e, Print)		19b. Mai	ling Address	S (Street	and Number or Ru	ral Route Numi	ber, City o	or Town, State	e, Zip Code)
alth a	er tre		Deborah Kahler				2 C]	lemtin	e Ct	. Roseda	le, MD	2123	7	
es 1 a of He	ę.		20a. Method of Disposition	2 🗆 Da	mount from St	- 1	Place of Disp cemetery, cre	osition (Nar	me of		Date			or Town, State
mit. Pages 1 ar	ury o		1 Burial 2 remation 4 Donation 5 Other		moval from St		esapea	ake Cr	emat	orv	Apr 8 2005	Bel	tsville	e, Maryland
ormit.	y inj		21. Signature of Funeral Service	License	°,)	MOOS	XI.			ss of Facility	1 214			
a 886	5 a		XX	re	v =			8717 G	reen	and Funera Pastures	Drive	Balt:		
	e -		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications	ations that cau cause on eac						or respiratory	arrest,		Approximate Interval Between Onset and Death
			Immediate Cause (Final disease or condition resulting in death)	a.	m	etast	ntee	Breas	TC	Ancee				years
			rosating in death)		Due to (or	as a conse	quence of):							J
		7	Sequentially list conditions,	b.	Due to (or	as a conse	nence of).							
peti	nsit	amine	if any, leading to immediate cause Enter Underlying Cause (Disease or injury	<		40 4 00 1100	44000 0.).							
axecu	al-tra	Exar	that initiated events resulting in death) Last	c.	Due to (or	as a conse	quence of):							
oo / ou, tificate be exe	e buri			d										
ificat	as the	edic		- 0.										
DOX eath cert	esn	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23	ic. If yes, outco	me of pregn		□Ectopic pi	regnancy				23d. Date of	
deat	od fo	sicie	in the past 12 months? 1 □ Yes 2 ☑ No			nt at time of		Other (sp					Month	Day Year
at the	etach	Phy	9 Unknown								1 00 011			
res th	peq	þ	Part II. Other significant condit	ions cont	nbuting to dea	th but not re	sulting in the	underlying d	ause give	en in Part I.				e to the cause of death? Probably 4 □Unknown
7	pluor	ted									10	Yes 2	Z(No 3□	Probably 4 Unknown
5 &	9.2.8	Completed									24a. Wa.	DDSV	prior	autopsy findings available to completion of cause of
e law req	oag	Col									1 ☐ Yes	ormed? 2 No	death 1 🗌 Y	res 2□No
	-	Be	25. Was case referred to medic examiner?		ospital:				Oth	26. Place of Dea				11
	ector, p		1 ☐ Yes	'''	1 ☐ Ing 28a. Date of		ER/Outpatie 28b. Time		28c. Injury	4 Nursing n	ome 5 ☐ Res 28d. Describe		6 Other (S	ipecity) 10 Spr @
hysicien:	I director	2			(Month.	Day Year)	Injury	M	Worl	k? Yes 2 □No	Edd. Doddingo	11017 111701	y cocurrou	
OI VITAL Physicien:	I director	$\vdash \mid$	27. Manner of Death 1 Natural 5 ☐ Pend	ing tigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									
ISION OF VICE stending Physicien: death.	the funeral director	$\vdash \mid$	27. Manner of Death 1 X Natural 5 Pendinvesi 2 Accident invesi 3 Suicide 6 Coulc	tigation I not be	28e. Place o	f Injury - At h	iome, farm, s		-		28f. Location	(Street an	d Number or	Rural Route Number,
lor Attending Physicien: after death. Director: After this certifies	the funeral director	$\vdash \mid$	27. Manner of Death 1 A Natural 5 □ Pendi 2 □ Accident invest 3 □ Suicide 6 □ Coulc	tigation	28e. Place o	f Injury - At h j, etc. <i>(Speci</i>	nome, farm, s		-		28f. Location City or To	(Street an wn, State	d Number or	Rural Route Number,
lor Attending Physicien: after death. Director: After this certifies	the funeral director	Certification; T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifyi	tigation I not be mined ing Physi	28e. Place o building	est of my kn	owledge, dea	treet, factory	y, office	ne, date and place	City or To	cause(s)	and manner	as stated.
Hospitel or Attending Physicien: 24 hours after death.	the funeral director	edical Certification: T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifyi	tigation I not be mined ing Physi	28e. Place o building	est of my kn	owledge, dea	treet, factory	y, office	ne, date and place	City or To	cause(s)	and manner	
ttending Physicien: death.	in by the funeral director	$\vdash \mid$	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medica	tigation I not be mined ing Physi I Examin	28e. Place o building	est of my kn	owledge, dea	treet, factory	at the time, in my op	ne, date and place	City or To	cause(s), date and	and manner d place, and c	as stated.

DHMH 17 Rev 1/2001

State

Registrar

Sports

6701 N. Charles St. Balts. MI 2(20)x

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 1 1 2005

32. Registrar's Signature

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of	Marylan	-	artment tificate			nd Me		giene Reg. No.	2005	12127
	Physici /Medio Examir	al	Decedent's Name (First, Middle, La Mary Elizabeth He 4a. Facility Name (If not institution, giv	ssenauer			4b. City, T	own, or	Location of		2. Date of De Month April	Day	Year 2005 County of Death	3. Time of Death 8:50 AM
	Funeral Director		214-18-7126		Age (In yrs. i	last birthday) Yrs.	If Under 1 Months		Baltim If Under 2 Hours		8. Date of Bir (Month, Da		9. Birth Cou	place (State or Foreign ntry)
	ne Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD			y.Town or Lo								10d. Inside City Limits
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or Items 23a or 28a-f show ther, the Medicel Examinat must be redified at	Completed by Funeral Dire	1006 E. Lake Aven 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	12. Was Deced Armed Force 1 Tes 2 If Yes, Give Year or Date	es? No es:	16a. Decec (Give life. I	10f. Zip 0 212 Was Decede f Yes, specif One of Yes dent's Usual kind of work DO NOT use	12 ent of His fy Cubar No Occupa done do retired)	specify: Specify: tion uring most	Puerto R		Unit	en of What Cou ced Stat 4. Race - Americ Black, White, Specify: Whit d of Business/In ver Manu	es can Indian, etc.
Maryland	should be and Mental s marked o	To Be (17. Father's Name (First, Middle, Last, Michael J. Ledlic 19a. Informant's Name/Relationship (h Type, Print)	£ 5305	248		Street a	Minni nd Number	ie A.		er, City or	Town, State, Zip	Code)
Baltimore, 1	permit. Pages 1 and 2 Department of Health Importent: If item 27 I any Injury or other tra		James L. Hessenau 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification 2) 21. Signature of Funeral Service Licer	Removal from St	ate C	lace of Dispo emetery, crem esapea	sition (Name natory or oth ke Cre . Name and remati	e of ner place emate Address	ory s of Facility	A 2 neral	pr 9 005 Alter	20c. Loc Belt nativ	21212 cation - City or To sville, es more, Ma	Maryland
8760,	Physician /Medical Examiner	Icai Examiner	23a. Part1. Enter the disease, or common shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence as a c	uence of):	er the mode	of dying	such as c EEC STA	ardiac or	respiratory a	rrest,		proximate Interval Between Onset and Death
.O. Box 68	death certifics e attending ph ed for use as t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		h 2 ☐ Fetal nt at time of de	death 3	Ectopic pre					2	3d. Date of delive	ery Day Year
Records, P.	The law requires that the de ste has been signed by the a bage 2 should be detached t	by	Part II. Other significant conditions of	ontributing to dea	th but not rest	ulting in the u	nderlying ca	use give	n in Part I.			obacco us	\/	ne cause of death?
Vital Rec		Se Completed	25. Was case referred to medical						26. Place of	of Death	24a. Was autor perfo	osy rned? 22 No	24b. Were auto prior to co death? 1 Yes	psy findings available mpletion of cause of
Division of V	Attending Physrdeath. sctor: After this by the funeral di	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place o		ER/Outpatien 28b. Time of Injury	28 M	c. Injury Work 1 🗆 Y	4 🔲 Nurs	0 28	8d. Describe I	now injury		y) al Route Number,
۵	To the Hospital or within 24 hours afte To the Funerel Direct completely filled in the funerel or the Funerel Direct completely filled in the funerel or the	Medical Cer	29a. Certifier (Check only one) 29 Medicel Exer	ysicien: To the b	est of my kno- is of examinat	wledge, death	estigation, i		inion, death		d at the time,	date and		the cause(s)
	N = 3 = 8		30. Name and address of person who	LLEC completed cause		23a) (Type,	1)/;	717	9		4	18/0	21204
DH	Sta Registi MH 17 Rev 1/2	ar	31. Date filed (Month, Day, Year) APR 1 1 200	32. Rec	gistrar's Signa						-,,			

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** HANNAH JOS EPH 0. 1740 aka Joseph Clifford 2005 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPITAL MONTGONFAY GRN MONTGOMEN OLNEY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2□F Director 181-16-1281 83 May 8, 1921 Pennsylvania Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits dren must be notified at Director MD Montgomery 1 ☐ Yes 2 ☐ No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 Bel Pre Road, #3 20906 Itams 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? VIEVes 2□No fives, Give Year or Dates: 1942 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Ital any injury or other traumatic event, the Medical Exar area. 2008. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 1943 Specify. 3 ☐ Widowed 4 ☑ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NIH Civil Service Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Clifford Hannah 2 Myrna M. Henderson Hannah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey O. Montgomery/Nephew 26 Greenway Lane, Dover, DE 19904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 4/7/05 ^¹ 4 □ Donation 5 ☐ Other (Specify) Beltsville, MD 22. Name and Address of Facility
Rapp Funeral and Cremation Ser
933 Gist Avenue Silver Spring, 21. Signature / Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** SACRAL DECUBITUS ULCER INFECTED Sequentially list conditions, any, leading to minimize the cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ director, page 2 should be ARTERY DUENSE 1 🗌 Yes 2No 3 Probably 4 Unknown Be Completed MELLITUS DIADETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 N 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

(Check only one) Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 600005/1m D050545 6/02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMPSHIRE AVENUE TAICOMA NEW 32 Aegistrar's Signature 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2005 **Physician** James Thomas Hughes Month 5, April 12:00 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5711 Rossmore Drive Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) M -250-F Director 214-36-4745 66 Dec. 19. 1938 Washington, D.C. Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location or 28e-f show ir then "naturel", or items 23e or 28e-f shov If a Modical Examinating the be notified at 10d. Inside City Limits Maryland Director Montgomery Bethesda 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5711 Rossmore Drive death 1 20814 Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other then "naturel", or Ite Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced It Yes, Give Year or Dates: Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Fire Protection Engineer Fire Protection other treumetic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 Lacy Farthing Hughes Virginia Coe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian B. Hughes 5711 Rossmore Drive, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Pages 1 Department of H Importent: If ite any injury or ot once. 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 TCremation 3 ☐ Removal from State Montgomery Crematorium, 4 ☐ Donation 5 ☐ Other (Specify) April 8, 2005 Bethesda, Maryland Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01420 WO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Lung Cancer 4 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? certificate 2☑ No 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🛱 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 👿 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Director: After that in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury death. 2 Accident M 1 ☐ Yes 2 ☐ No 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 101 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0033293 April 5, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick P. Smith, O.D.

5454 Wisconsin Avenue, #1300,

ORIGINAL

32. Registrar's Signature

allers Di

Chevy Chase, MD

20815

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

		1 - For State Registrar	State of Mar	yland	-	artment					Reg. No	6 U	05	121	3(
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, La. FRANK 4a. Fecility Name (If not institution, give	a street and number)		LE PITAL		Fown, or	Location o		2. Date of D APRIL RF	0 C		Year O 5 of Deeth	3. Time of D	PM
Funeral Director		5. Social Security Number 6. S	ex 7. Age (st birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of B (Month, D January	irth Day, Year 5, 1	955	Cour	plece (State or I ntry) land	Foreig
the Maryland 28a-fehow notified at	Director	10a. State 10b. County Maryland Baltimor 10e. Street and Number			Town or Lo	cation	Code				10g. C	tizen of V	Vhat Cour	1 Od. Inside City 1 ☐ Yes 2	
be filed within 72 hours after death with the Maryland hal Hygiene. Id either than "natural", or Itams 23a or 28a-f show event. Ins Madical Examinar must be notified at	by Funeral	1722 Earhart Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	er in U.S.		21221 USA							k, White,		
d within giene. er than	e Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)			(Give	dent's Usual kind of work DO NDT use Carpent	k done d e retired) CEY	uring most		g (First, Middl	Amt	rack	isiness/In	dustry	
al yio	To Be	William Insley 19a. Informant's Name/Relationship (Гурө, Print)			-	(Street a	Doris	Ellio or or Rural	ntt Route Numi	ber, City	or Town,		Code)	
1 2 5 E E	10000	Doris B. Insley/Wife 20a. Method of Disposition 1 Disposition 1 Disposition 1 Disposition 1 Disposition 5 Other (Specification)	Removal from State	20b. Pla	1/22 E ce of Dispo netery, cren and Me	sition (Nam	e of her place	Ţ	1more Da 4/13/		20c. L		City or To	own, State	
permit. Pages Department of I important: If its eny injury or or once.		21. Signature of Funeral Service Licer	See Christina L	on		Name and eopard 305 Har			hc Bålti	more Ma	ırylar		214		
Physician /Medical Examiner	r	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Due to (or as a c	Econseque	PSince of):		or aying	, such as	cardiac or	respiratory a	arrest.			Approximate Interval Betwe Onset and De	en ath
death certificate be executed eath certificate be executed eathending physician and idor use as the burial-transit	lical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c												
death certific e attending p id for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 5 Other (specify) 9 Unknown 73c. 73									23d. Date of o Month			delivery Day Year		
law requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but r	not resulti	ing in the ur	nderlying ca	use givei	n in Part I.						ne cause of dea	
ician: The law i	e Completed	25. Was case referred to medical								1 ☐ Yes	ormed?	8	rior to cor eath?	psy findings ava npletion of caus 2000 No	ailable se of
S S D	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: Inpatient 28a. Date of Injury (Month, Day Y	2	NOutpatien 8b. Time of Injury	28	c. Injury Work	ີ 4 □ Nur at	rsing Home	Check only 5 Res d. Describe	idence			1)	
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			e, farm, stre	M eet, factory,		es 2 N		f. Location City or To	(Street ar own, State	nd Numbe	or or Rura	l Route Numbe	r,
To the Hospi within 24 hour To the Funer completely fill	edicai	(Check only 2 ☐ Medical Examone)	ysician: To the best of n hiner: On the basis of ex and manner stated	aminatio d.	n and/or inv	estigation, i	n my opi	nion, deat	h occurred	at the time,	date and	d place, a	nd due to	the cause(s)	
or with	<	29b. Signature and title of certifier MGVVCCCC 30. Name and address of person who	Bahl completed cause of deat	l h (Item 2	MD 3a) (Type. I	29c.	License O C	5 8	391:	3	APR	1 L	9	2005	-
Sta Registr	ate rar	29b. Signature and title of certifier Movement 30. Name and address of person who of the control of the contr	32. Registrar's	Signatur	Social S	601	Lo	CH	RAV	ENBA	BO	ULE	VAR E, N	10 212	-36

DHMH 17 Rev 1/2001

O the Hospital Within 24 hours of the Funesal Completely filled Completely filled DHMH 17 Rev 1/2001

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ss of person who completed ca

of death (Item 23a) (Type, Print)

OCME

111 Penn Street

6, 2005

APRIL

Baltimore, Maryland 21201

			State Amend Ite	n 23a per 1 m 23b&25 pe	aryland Department (1974) er me G842	711705dhb rtificate of L	ealth and M Death 4 -21-	ental Hygic 05 tas 🗝	ene 005	12132
	Physici		1. Decedent's Name (First, Middle, Willia	Last) am Koehler				2. Date of Death Month APRIL 5,	Day Year 2005	3. Time of Death 7:45a M
	/Medio Examin		4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death		4c. County of Death	
			Anne Arundel Me				apolis		Anne Ar	
	Funeral Director		213-03-0300	6. Sex 7. Ag 1 M 2 □ F	ge (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y NOV 18,	1916 Mary	place (State or Foreign http:) 7Land
	with the Maryland a or 28a-f show be incilling at	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f	Director		Arundel		Annapoli	is	10-	Citizen of Miles Cou	
	th with t		10e. Street and Number 933 Edgewood	Road Apt.		10f. Zip Code 214			g. Citizen of What Cou USA	
980	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Items 23a or 28a-f show ent, the Medical Exertinetricust be inclified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 🏋 Widowed 4 □ Divorced	12. Was Decedent Armed Forces' od 1 ∑ Yes 2 ☐ If Yes, Give Year or Dates:	No	37	spanic Origin? (Spe n, Mexican, Puerto f Specify:	cify Yes <i>o</i> r No- Rican, etc.)	14. Race - Ameri Black, White, Specify: WI	
Baltimore, Maryland 21215-0036	thin 72 hours 6. an "natural', Medical Exi	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	(Give	DO NOT use retired	furing most of workir		6b. Kind of Business/In	•
21	be filed withintal Hygiene. Ind other than event, the M	Con	12			Manager	40 Markada Nassa	/F:	Drug Sto	ce
/land	be de la	To Be	17. Father's Name (First, Middle, L Unk .	Koehler			18. Mother's Name Christ:	ina Bauei	•	
lar,			19a. Informant's Name/Relationshi						City or Town, State, Zip	
2	l and lealth m 27 her tr		Charlotte Koehl	er Kerr/dau					S, MD 2140 ^t Oc. Location - City or To	
imore	0 0		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Donation 5 □ Other (Sp			osition (Name of matory or other place	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		Baltimore	
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service L	mcDonald	10 2	Charland 1000s	ssociety o		and, Inc. ore, MD 212	228
	Physician /Medical Examiner	_	23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. huffa	ine.	er carbic 1	apiratory	For line	t,	Approximate Interval Between Onset and Death
o,	ificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):		CATION APPROVED BY	MEDICAL EXAMINE	R	
68760,	cate be physicia the but	edical		d		CERTIFIC	CATION APPROVED			
P.O. Box 6	ne death cert the attending hed for use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
	ires that the signed by do be detac		Part II. Other significant condition	ns contributing to death t	out not resulting in the u	nderlying cause give	en in Part I.		cco use contribute to t	
of Vital Records,		Completed						24a. Was an autopsy performe	prior to co death?	opsy findings available impletion of cause of
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Marriado		0.5	26. Place of Death	(Check only one)		
of	Physi this c	Jo	Yes 201No 27. Manner of Ceath	Hospital: 1 Inpati			4 C Indianing Field	ne 5 Residence	ce 6 Other (Special	(y)
O	Attending Physician: " death. ector: After this certifics by the funeral director, I	tlon	1 Natural 5 Pending 2 Accident investigation		y Year) Los. Injury	Work	(?` Yes 2 □ No		injury occurred	
Division	- 0 -	Certification;	3 Suicide 6 Could not determine	200. Place of Ki	jury - At home, farm, str tc. (Specify)	reet, factory, office	2	Bf. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
)	To the Hospital or within 24 hours after To the Funeral Dir completely filled in I	Medical Ce		Physician: To the best xaminer: On the basis of	of examination and/or in					
	To the within To the comple	Med	29b. Signature and title of certifier		`	29c. License	18809	290	I. Date signed (Month,	
			30. Name and address of person w	Fru Ma	death (Item 23a) (Type,		, 050/		pil 5, 05	
			Barbara Furlow	, M.D. Ar	ne Arundel	Medical	Center			
	Sta Registr		APR 1 1 20	32. Regist	rar's Signature					

	1- For State of Many	yland / Department of Health and Ment Certificate of Death	ral Hygiene
Physician /Medical	Decedent's Name (First, Middle, Last) WILLIAM W. KNODE		ate of Death lonth Day Year 07:05M
Examiner Funeral Director	4a. Facility Name (If not institution, give street and number) 1 1 2 1 3 U 1 5 I M 5. Social Security Number 6. Sex 1 M 2 F 86	nlyrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. D. Months Days Hours Min.	4c. County of Death CE TAY FOR A ate of Birth fonth, Day, Year) 26/1918 9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent	Oc. City, Town or Location	10d. Inside City Limits
with the Mary s or 28a-f sh te nixtified a	MD HARFORD 10e. Street and Number	BELAIR	1 ☐ Yes 2 XNo
er death v	300 W RING FACTORY ROAD 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 □ Divorced 1 Never Married 2 Married 3 □ Widowed 4 □ Divorced	ar in U.S. 13. Was Decedent of Hispanic Origin? (Specify New York, Specify Cuban, Mexican, Puerto Ricar	USA
21215-0C ed within 72 hou ygjen natura er than 'natura er tta Musical E	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR	16b. Kind of Business/Industry INSURANCE UNDERWRITERS
Aaryland 2 2 should be filed and Mentalled 1 is marked other raumatic event, To Be C.	17. Father's Name (First, Middle, Last) WILLIAM W. KNODE, SR.	18. Mother's Name (Firs ELLA CONWA	t, Middle, Maiden Sumame) Y
e, n t and tealth sm 27 ther t	1XXBurial 2 Cremation 3 Removal from State	19b. Mailing Address (Street and Number or Rural Rout 405 PLUMBRIDGE COURT UNI 20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY 4/9/200	T 302 TIMONIUM, MD 21093 20c. Location - City or Town, State
Baltimorr permit. Pages Department: If ite any injury or ot	21. Signature of Funeral Service Licensee	22. Name and Address of Facility THE JC 8521 LOCH RAVEN BLVD.	HNSON FUNERAL HOME, P.A. TOWSON, MD 21286
8760, sate be executed hysician and the burial-transit alcal Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	ratmetation	3 WKL
Box 6 sath certific attending p for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of a continuous properties of the past 12 months? 4 □ Pregnant at time points properties of the past 12 months? 4 □ Pregnant at time points properties of the past 12 months	Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Cords, P.O. Mequires that the de been signed by the should be detached	Part II. Other significant conditions contributing to death but n	ot resulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 M(No 3 ☐ Probably 4 ☐ Unknown
of Vital Records, Physician: The law requires to this certificate has been signe and director, page 2 should be completed by			4a. Was an autopsy available prior to completion of cause of death? ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
of Vital Of Vital Physician: this certifica	25. Was case referred to medical examiner?	26. Place of Death (Che	ock only one)
ding Atte	1 Yes 2 No 10 In Inpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Inpatient 28a. Date of Injury (Month, Day Yo	2 EH/Outpatient 3 DOA 4 Yoursing Home	5 Residence 6 Other (Specify) Describe how injury occurred
Division of To the Hospital or Attending P Within 24 hours after death. To the Funeral Director: After I completely filled in by the funeral Medical Certification;	€ Could not be		ocation (Street and Number or Rural Route Number, ity or Town, State)
Divi		ny knowledge, death occurred at the time, date and place, and di amination and/or investigation, in my opinion, death occurred at f.	
To the within compa	29b. Signature and title of certifier	29c. License number D 3 2-6 cq	29d. Date signed (Month, Day, Year)
6317	30. Name and address of person who completed cause of death		vrede Goule MD 21678
State Registrar	31. Date filed (Month, Day, Yapp 11 20 Progistral)		

			- POI	epartment of Health and Me Certificate of Death	ental Hygien	2005 12136
	Physicia /Medic		Decedent's Name (First, Middle, Last) Amadis Pagan Lopez		April 8,	2005 3. Time of Death 2:45 p ^M
<i>)</i> 	Examin Funeral	6	4a. Facility Name (If not institution, give street and number) Manor Care 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	4b. City, Town, or Location of Death ROSSVIILE day) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Data of Birth	c. County of Death Baltimore 9. Birthplace (State or Foreign Country)
	Director		201 – 24 – 4522 1 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	·s.	(Month, Day, Yea Dec. 1,192	
	e Marylar 8a-f ehow	ctor	10a. State10b. County10c. City, Town of Essential ControlMarylandBaltimoreEssential Control	ex		10d. Inside City Limits 1 ☐ Yes 2√☐ No
	vith th	Dire	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	ath v	Ta .	701 Platinum Avenue	21221		.S.A.
36	urs after de al', or Items	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Syes 2 No If Yes, Give Korea	 Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto Ri \infty Yes 2 □ No Specify: Puerto Ri 		14. Raca - American Indian, Black, White, etc. 1. Specify: Hispanic
21215-0036	permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Ia marked other then "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, I'm Medical Examination in Item 2016.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of working ife. DO NOT use retired)		Kind of Business/Industry
	led w lygier her th	S		ctronic Technician 18. Mother's Name (estinghouse
Maryland	ould be fil Mental H arked otl	To Be	17. Father's Name (First, Middle, Last) Anastasio Pagan	Pascacia I		n sumame)
	alth and 2 sho		1 1 2 1 1 1	Mailing Address (Street and Number or Rural I 1 Platinum Avenue, Es		
Jre,	item item		20a. Method of Disposition 20b. Place of Dis	Disposition (Name of Date crematory or other place)	te 20c.	Location - City or Town, State
Ē	Page nent a			nd Mem. Park April	13,2005 I	Baltimore, Maryland
Baltimore,	permit. Departr Imports any inj		21. Signature of Funeral Service Licensee	^{22. Name and Address of Facility} Bruzdzinski 1407 Old Eastern Av	Funeral Ess	Home, P.A. sex, Maryland 21221
The state of	Fnysician /Medical Examiner	ner	Approximate Interval Between Onset and Death			
8760,	icate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C):		
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ecords, P.	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	1	o use contribute to the cause of death? 2 No 3 Probably 4 Micrown
\propto	The ate ha	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ 10
Vital	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
of <	Physician: r this certific ral director,	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp			6 ☐Other (Specify)
U C	ding P. h. After t funera	on:	27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Tin	ury Work?	d. Describe how inj	ury occurred
Division	or Attenditter deati	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 Tes 2 No 1, street, factory, office 28	f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or within 24 hours after To the Funeral Dit completely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.			
)	To th withir To th	×	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
	MY		30. Name and address of person who completed cause of death (Hem 23a) (T	Dr Bonh Andrew	chlone	d. Cosed MD2122
	Sta Registr	-	31. Date filed (Month, Day, Year) APR 1 1 2005	uk		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2005 9, Sylvia ٧. Lambros April 7:45 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, August 3, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Year) 1938 **Funeral** Months Hours Days 1 □ M 2 ☑ F Maryland 66 219-26-4322 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b Counts in than "natural", or Items 23s or 28s-f show the Medical Examiner must be redified at 1 Yes 2 No Baltimore Butler MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21023 U.S.A. 16230 Falls Road, P.O. Box 67 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: φ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within. h and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Cun hame Homemaker or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or othar traumatic event ODGE. 17. Father's Name (First, Middle, Last) Be Glaros Clara Varlas Steve 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16230 Falls Rd., P.O. Box 67, Butler, MD 21023 Michael J. Lambros-husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/13/05 Baltimore, MD Greek Orthodox Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 Yark Rd., Tawson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death years Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, i.e., y, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attanding Physician: ral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No 6 ☐Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After within 24 hours after death.

To the Funeral Director: Afte completely filled in hours. 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 06 29d. Date signed (Month, Day, Year)
April 10th 2005 29b. Signature and title of certifier

State Registrar

Klealhu

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Sirect, Balkmore MADHU CHAUDHRY, 6569 NORM Charles Sirect, Balkmore

			For State Registrar		State	of Mar	yland		artmen			and M	ental Hy	giene	005	12136
			Decedent's Name	(First, Middle,	Last)							-	2. Date of De	ath		3. Time of Death
Н	Physici		Maria L	umaro									Month April	Day 4 -	Year 2005	3:00P M
	/Medic Examin		4a. Facility Name (If		give street and	number)			4b. City,	Town, or	Location of	of Death			County of Dea	
1			715 016	1 N.	Point	Road					Balti	more		Ва	altimor	e
Ī	Funeral		5. Social Security Nu		6. Sex 1 □ M 2 € 1	7. Age (st birthday	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da	th y, Year)	9. Bi	rthplace (State or Foreign
	Director		216-68-28		1 □ M 2451		65	Yrs.					04/17			* '
	pus *		Usual Residence of 10a. State	10b. County		1	10c. City.	. Town or L	ocation							10d. Inside City Limits
	sho	5														1 ☐ Yes 2 No
	the A	Director	MD 10e, Street and Num	Balti	more		ват	timor	10f. Zip	Code				10a. Citi:	zen of What C	ountry?
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	ter death with the Marylar Items 23a or 28e-f show included by coefficial at	Funeral	11. Marital Status	VOI CII P	12. Was E	ecedent Ev	er in U.S	S. 13.			ispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Am	
10	ritar	F	1 Never Marrie	ed 25 Marrie	d 1 ☐ Ye	Forces?						, Puerto	Rican, etc.)		Black, Wh	ite, etc.
93	hours after death with the Maryland turel', or Itams 23a or 28e-f show al Examenational be codiffied at	ρ	3 ☐ Widowed	4 Divorced	If Yes, Year o	Giver or Dates:			1 ☐ Yes	214W0	Specify:				Specify: Wh	ite
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Maryland	12 sho h and h 7 is me traume	i	19a. Informant's Na Anthony I													
d)	s 1 and 2 should if Health and Mer itam 27 Is marke other traumatic		20a. Method of Disp		/ husb	and	20b. Pla	ace of Disp	osition (Nar	ne of			oad Bal		cation - City o	
Baltimore,	ages nt of nt of :: If it		1 ☐ Burial 2 €	Cremation		om State	Ce	metery, cre	matory or o	ther place	1		Apr 6			
Ē	it. Partiment		4 ☐ Donation21. Signature of Fur			1	Che	-	ake Cr 2. Na <i>m</i> e ar				2005	ветт	sville	, Maryland
Ba	permit. Pages 1 Department of F Importent: If its any injury or ot		21. Signature of the	- Hali	ll	Mo	०१४()		Cremat	ion a	and Fu	inera	l Alter			
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			shock, or hear Immediate Cause (I	t failure. List o	nly one cause o	n each line.	- +	6.7	0	10						Interval Between Onset and Death
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89	death certificat attending phy d for use as th	Physician/Med	IF FEMALE:	127												
Вох	Ith ce tendi	an/I	23b. Was decedent in the past 12 r			outcome of e birth 2			⊒Ectopic pr	egnancy				2	3d. Date of de	livery Day Year
		SICI	1 ☐ Yes 24 €			egnant at tin iknown	me of de	ath 5	Other (sp	ecify)				į	WOTE.	Day . Jul
P.0	ac ac	Phy	Part II. Other signifi	cant condition	a contribution t	o donth but	not rocui	ting in the	andorhian o	auca anz	on in Part I		23e Did to	obacco u	se contribute t	o the cause of death?
s,	es De	þ	Faith. Other signin	cant condition	is continuating t	o death but	1101 19301	ung ar ure t	andenlying C	ause give	311 III 1 Q.I.(.).		,			robably 4 Dunknown
orc	v requir been s should	eted														
Record	S S S	Completed											24a. Was autop		24b. Were a prior to death?	utopsy findings available completion of cause of
	Th ate pag	S												212 No	1 ☐ Ye	s 2 No
Vital	Physician: Th this certificate ral director, paç	Be	25. Was case referrence examiner?		Hospital:				****	Othe			(Check only o			
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isi	for Attanding atter death. Diractor: Aftel In by the fune	lical	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could n	ot be	ace of Injury	/ - At hor	ne, farm, st					28f. Location (S	Street and	1 Number or F	ural Route Number,
Division	lor A after Dira	Certification;	4 🗌 Homicide	determi	pi	ilding, etc. ((Specify)		,	,			City or Tox	vn, State)		
	Hospital 14 hours a Funeral I				Physician: To											
	To the Hospital or Attanding Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only one)	2 Medical E		e basis of ex anner state		on and/or ir	vestigation	, in my op	oinion, dea	th occurre	ed at the time,	date and	place, and du	e to the cause(s)
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	V		30. Name and addre	ess of person y	no completed of	ause of dea	th (Item	23a) (Type	Print)	EN	Terr	Ave	BAS	1 1 mail	ve mol	2/224
	Sta Registr	-	31. Date filed (Monti	APR I	1 2005	Registrar's	s Signati	TI-B	back	,					J	,

Jonathan L. Lesniewski Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05 - 2368State of Maryland / Department of Health and Mental Hygiene, AKG 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 4, 2005 **Physician** 1:40 P M Jonathan Lee Lesniewski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Pasadena 7863 White Cove Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/03/1984 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**X** M 2□ F 20 Yrs Director 220-17-8540 Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State r than "natural", or Items 23a or 28a-f show the Medical Examinat roust be inclined at 1 ☐ Yes 2 1 No Director MD Anne Arundel Pasadena the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 U.S.A. 7883 Whites Cove Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: þ White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 Installer and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 2008. Be Genevieve L. Lipsky Thaddeus Paul Lesniewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7883 Whites Cove Road, Pasadena, MD 21122 Thaddeus Lesniewski/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/08/05 ³ 4 □ Donation 5 □ Other (Specify) Baltimore, MD Holy Cross Cem 22. Name and Address of Facility G.J. Gonce Funeral Home, PA 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the direct. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ongin Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a nonsecuence of Examiner be executed Due to (or as a consequence of): burial physician 68760 Physician/Medical certificate Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) Ö 9□ Unknown 9 🗀 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other (Specify) at scene 2 1 X Yes 2 ☐ No 27. Manner of Death 28a. Late of Injury Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural 28f. Location (Street and Number or Rural Route Number, City or Town, Street 05 1 🗌 Yes 2 Accident after death 28e. Plac of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 4 ☐ Homicide determined 21122 MONE 3 within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signal and title of certifier

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

APR 1 1 2005

Registrar's Signature

of death (Item 23a) (Type, Print)

OCME

April 5, 2005

111 Penn Street Baltimore, Maryland 21201

		For Stete Registrar	State of Ma			tment ificate			ariu IV		eg. No.	000	2 3 8
Physicia /Medic	al	1. Decedent's Name (First, Middle, Myra Lath	inghouse					-		Month MARCH	Day	2005	03:15 PM
Examin		4a. Facility Name (If not institution,	give street and number)	AL				Location o				y of Death	
Funeral Director		5. Social Security Number 213–26–2220	6. Sex 7. Ag 1 ☐ M 2 💢 F	je (In yrs. last bi 75		If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Dec 11,	^{Year)} 1929	9. Birthp Cour	lace (State or Foreign htry) unk
72 hours after death with the Maryland naturel, or ltems 23a or 28a-f show deat Everthwermat be rediffed at	_	Usual Residence of Decedent 10a. State 10b. County MD		10c. City, Tow								1	0d. Inside City Limits 1 √2 Yes 2 □ No
or 28a-f sho	Director	10e. Street and Number			Dalt	imor 10f. Zip (1	0g. Citizen of	What Cour	
23a or	rai D	22 Athol Aven					2122				USA		
al', or Items	by Funerai	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? ad 1 Tyes 2 2 1f Yes, Give Year or Dates:			as Decede Yes, speci ☐ Yes 2		spanic Ori n, Mexicar Specify:	gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ack, White, fy: Wh	
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Mental Hygiene. narked other then	Be	unk 17. Father's Name (First, Middle, L	unk ast)			1	ınk	18. Mothe	r's Nam	e (First, Middle,	Maiden Suma	тө)	unk
and sun	2	19a. Informant's Name/Relationsh								al Route Number	-	*	
perfill. rages I are to Department of Health Importent: If Item 27 any injury or other tri		St. Agnes Hospi 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp.	3 □Removal from State	20b. Place o		tion (Nam	e of			Date	20c. Location	21229 - City or To	
Departm Departm Importer any injur		21. Signature of Euperal Serviced		- / /		Name and timo		_	ŏard 2120	655 W.	Baltin	ore S	treet
Physician and // // // // // // // // // // // // //	i Examiner	23a. Part. Enter the disease, or shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	d the death. Do ine. LIATER a consequence a consequence a consequence	2A2 • of):						est,		Approximate Interval Between Onset and Death WEEKS
by the attending physic tached for use as the b	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	d	2 Fetal death		etopic pre						ate of deliver	ory Day Year
uires inat it signed by id be detac	d by Pł	Part II. Other significant condition	ns contributing to death t	out not resulting	in the und	lerlying ca	use give	n in Part I			bacco use cor es 2 □ No	ntribute to th	ne cause of death?
I ne law requires mat the death certifica ate has been signed by the attending phy page 2 should be detached for use as th	Completed									24a. Was a autops perfor		Were auto prior to con death? 1 \(\text{Yes} \)	psy findings available mpletion of cause of
certificate	Be	25. Was case referred to medical examiner?	Hospital:				Othe			h (Check only or			
nding Phys th. r: After this e funeral di	ation: To	1 Yes 27 No 27. Manner of Death 1 Alatural 5 Pending 2 Accident investig	28a. Date of Inju	ury 28b.	Time of Injury	3 DO	c. Injury Work	at		ome 5 Resid			y)
To the Hospital or Attending Physicien: within 24 hours after dear After this certificator the Funerel Director. After this certificatomplately filled in by the funeral director, it	Sertific	3 Suicide 6 Could n 4 Homicide determi	nod 286. Place of In	jury - At home, f tc. <i>(Specify)</i>	farm, stree	et, factory,	office			28f. Location (S City or Tow		ber or Rura	l Route Number,
To the Hospital or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Medical Certification:	29a. Certifier (Check only one) Certifying 2 Medical I	g Physician: To the best Examiner: On the basis of and manner st	of examination a	ge, death ound/or inve	stigation,	in my op	inion, dea	d place, th occur	red at the time, o	ate and place	, and due to	the cause(s)
To t To t com	M	29b. Signature and title of certifier	- OR.				PIL	number	3	r	9d. Date sign	100	9 2005
		30. Name and address of person of the state	# 32 Pagist	rade Signatura		M I	NE	NUI	= (BALTI	MORI	E, N	11) 21229
Sta Registr		31. Date filed (Month, Day, Year)	05 Block	H A	book								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2:45 LAUER 5 APRIL 2005 CAROLYN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min THE JOHNS HOSPITAL HOPKINS Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 20 F 13-42-117 600 Director -9-44 Hebron Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or Items 23a or 28a-f show treumatic event, the Medical Examinations to the redified at 1 ☑ Yes 2 ☐ No Director Hebron WITCOMICO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Bradley 21830 USA 106 by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after ☐Yes 2 Mo Yes, Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "say injury or other treumatic event, Ite Meany injury or other treumatic event, Ite Meany office. Elementary/Secondary (0-12) College (1-4or 5+) OFFICE WORKER Habitat 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JONES Walter Martin HUDREY IANKARID 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mobile Thomasville, PA rive COTT Lauel 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 21 20a. Method of Disposition Date 371 KINGS 1 Burial 2 Cremation 3 Removal from State 05 ,PA 17403 * 4 ☐ Donation 5 ☐ Other (Specify) Cremation Direct Service YORK 822 E. Market 22. Name and Address of Facility 21. Signature of Funeral Service Licensee John Danne John. 1740 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 48 HOUDS CEREBRAL HERNIATION disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner DAVIS MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed YEAR Due to (or as a consequence of) DISEASE use as the burial-tran the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 K No Month Day Year ę 5 Other (specify) 4 Pregnant at time of death detached 9□ Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 APRIL 5, 2005 JASON DAVID ARCHIBALD, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JASON DAVID Anchien M. M.D. GOO MONTH WOLFE STREET BALTIMONE, MANYLAND 21287 31. Date filed (Month, Day, Year)
APR 1 1 2005 32. Pagistrar's Signature State

Registrar DHMH 17 Rev 1/2001

De Sperke

Registrar

State

31. Date filed (Month, Day, Year)

APR 1

32. Register's Signature

		•	For State Registrer	State of	Marylar		artment rtificate			ind Me		giene	2005	121	L		
	Physicia	an	1. Decedent's Name (First, Middle,				-1				2. Date of Dea Month APRIL		2005 ^{Year}	3. Time of			
	/Medic	al	Rosemar 4a. Facility Name (If not institution, g		nher!	M	alone	Town or	Location o		APKIL		2005 County of Death	7:10	Ам		
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	land		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						1	10d. Inside Ci	ity Limits		
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	or 28	Director	10e. Street and Number				10f. Zip						en of What Cou	•			
	eath w	erai	26400 Aiken Drive		ident Ever in I	ant Ever in U.S. 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer					ifv Yes or No-	ates ican Indian,					
36	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or ttems 23e or 28e-f show ith, the Medical Ezana or must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo	rces? 2 🔼 No re	7.0.	If Yes, spec		Specify:	Puerto R	ican, etc.)	Black, White, etc. Specify: White					
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il di	should nd Me mark mark	ို	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	Berdjouhie Gueuzubeuyukian (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "netural; or Items 23e or 28e-f show any injury or other treumatic event, the Medical Exandrat must be notified at ance.	1	Martin A. Malone	e/ Son									ryland				
Baltimore,			20a. Method of Disposition 1	Removal from	Sizie	Place of Dispo cemetery, cre				Da			cation - City or T				
ţ			* 4 ☐ Donation 5 ☐ Other (Spe	cify)	Pin	e Grov			-				Airy, M		ıd		
Bal	21. Signature of Edneral Service Licensee 22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											al Home ryland	20872 Approximat				
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rds, P	es this	by	Part II. Other significant condition	s contributing to d	eath but not re	sulting in the t	underlying c	ause giv	en in Part I.		23e. Did to		se contribute to		death? Unknown		
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of	Ing After uner	<u> -</u>	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigs	28a. Date (Mon		28b. Time of Injury		28c. Injun Wor	y at	2	8d. Describe i			ny)			
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	/-	Σ	29b. Signature and title of certifier						e number				e signed (Month	_			
,			lan Ban		. 0 .	- 00-1 7		NDC	5000	35		Apr	100	3,20	20		
Í	0		30. Name and address of person we Paul Banner M.					V P	Olnev	Mar	vland	# 32	7				
	Sta	ate	31. Date filed (Month, Day, Year)	1 2005 J	Registrar's Sign	nature	/ DIT	, e <u>,</u>	OTILEA	, rial	y Land	, ,2					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				1- State of Maryland / Department of Health and M Certificate of Death		Reg. No	DODE	12162	2
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		/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		40	. County of De		_
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	ı	Funeral Director		5/8-20-4099 10 11 24 83 11s.	8. Date of Bi (Month, D	ay, Year		irthplace (State or Foreig Country) ennessee	חנ
		and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	-			10d. Inside City Limits	s
dato	-	death with the Maryland ms 23a or 28a-f show findst be millied at	ctor	Maryland N/A Baltimore				XXYes 2 ☐ No	О
8		with the	Funeral Director	10e. Street and Number Apt. 305 21211		-	tizen of What	Country?	
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3	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examination unit be multilled at 800ce.	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2☒ No Specify: Year or Dates:			Black, Wi Specify: B	lack	
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	tim	t. Pag tment tant: I		'4 □Donation 5 □Other (Specify) Greenmount Cemetery	1			,Maryland	me
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	Р.	that the ned by detac	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco	use contribute	to the cause of death?	
	rds	w requires been sign should be	ed b	TYPE II DIABETES MELLITUS	1 🗆	Yes 2	□No 3□	Probably 4 Onknown	n
	ecc	e law re has be je 2 sho	Completed	HYPERTENSION		s an opsy formed?	24b. Were prior to death	autopsy findings available completion of cause of	0
	al B	iclan: The certificate t ector, pag		RENAU CEUL CANCER. 25. Was case referred to medical 26. Place of Death	1 ☐ Yes	2 E No	1 Y	es 2 No	
	Ζ	ysicial s certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No			6 □Other (Sp	pecify)	_
	on of	Attending Physician: The lar ar death. ector: After this certificate has by the funeral director, page 2.			28d. Describe	how inju	ry occurred		
	Divisi	Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	C Could not be	28f. Location City or To	(Street a	nd Number or e)	Rural Route Number,	
		To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a control of					
		To the within 2 To the complete	Me	29b. Signature and title of centified 29c. License number				nth, Day, Year)	
)	de	_	MA, DL. D. KES-000		Apr	113,0	1005	
	1			30. Name and address of pelson the completed cause of death (Item 23a) (Type, Print)	TAL	OFF	SAITI	4005 MORE	
		Sta		31. Date filed (Month, Day, Year)	. 1 11	-11			
		Reaistr	ar	ADD 11 7003					

			1 - For State Registrar	State of M	arylan		artment rtificate				R	eg. No	005	12113			
	Physici	an	1. Decedent's Name (First, Middle, Last) Lillian			Myer	_				Date of Dea Month April	Day	Year	3. Time of Death 4:40 p M			
	/Medio		4a. Facility Name (If not institution, give s	street and number)		myer		Гоwп. or I	Location of		APTI		2005 Inty of Death	1.10 P			
	Examir	er	Johns Hopkins Bay			Center			more			/	VIA				
	Funeral		Social Security Number 6. Sex		ge (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 24	4 Hrs. 8	Date of Birth	Year)	9. Birthr	place (State or Foreign			
	Director		212-32-0399]M 2) Ç1F	6	9 Yrs.					May 28			* *			
	land		Usual Residence of Decedent 10a. State 10b. County	-	10c. Cit	y, Town or Lo	cation						1	I Od. Inside City Limits			
	Mary F sh	tor	MD. N/A			Baltim	ore					MXYes 2[
	or 28e	Funeral Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Cou	ntry?			
	23a c	rai	512 South Oldham S	treet				1224					USA				
	er deg	nne	The trial dialog	12. Was Decedent Armed Forces? 1 ☐ Yes 2X	Ever in U	ver in U.S. 13. Was Decede If Yes, speci			panic Origi , Mexican,	n? (Speci Puerto Ri	ty Yes or No- can, etc.)		Race - Americ Black, White,				
36	Irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ ② Divorced	If Yes, Give Year or Dates:	NO		1 ☐ Yes 2	No No	Specify:			Spe	ecity: W	hite			
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-f show acal Examinar must be profitted at	ted	15. Decedent's Edu	cation		16a. Deced	dent's Usua	Occupa	tion	é wadina		16b. Kind o	f Business/In	dustry			
215	within 7 lene. than "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)												
12	filed w Hygier other th		12 years 17. Father's Name (First, Middle, Last)			Bar	Tende		19 Mother	e Name /	First, Middle,	Bar Wajdan Sun	namal				
anc	ntal H	Be C	Charles Welch								Houch		/aille/				
Maryland	should nd Men marke	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or										or Town, State, Zip Code)				
	alth a		Linda Buckler	daughte	er	1902	Aster	Road	d, Ros	sedal	e,MD.	21237					
Baltimore,	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event, the Martical Examinar must be institled at	1	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State	0	Place of Dispo cemetery, cren	natory or ot	her place	A	pril	13,	20c. Locatio	on - City or To	own, State			
ţ	Page tment tent: If jury o		*4 ☐ Donation 5 ☐ Other (Specify)		Sacr	red Hear			em.	200	5	Dunda	lk,MD.				
Bai	permit. Pages 1 an Department of Heal Importent: If item 2 any njury or other once.		21. Signature of Funeral Service License	200		C 7	onnel. 110 Sc	ly Fi 011e	inera inera rs Po	l Hom	ne Of D Road, D	undal undal	k, P.A k,MD.	21222			
	Physician		23a. Party Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each li	d the deat ine.		er the mode	of dying	, such as ca	ardiac or r	espiratory arr	est,		Approximate Interval Between Onset and Death 3 olays			
	/Medical Examiner		resulting in death)	Due to (or as										2.2			
		-	Sequentially list conditions,	Due to (or as	umo a conseq									lolays			
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or rijur) that initiated events			,							9				
ó	an an		resulting in death) Last	Due to (or as	a conseq	uence of):											
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical															
9	ertifica ling pl	/Med	IF FEMALE:	On If was autooms	of												
Вох	eath certifi attending for use as	sian/	in the past 12 months?	3c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Feta	Ideath 3	Ectopic pre					23d.	Date of delive Month	ory Day Year			
P.O.		ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown			, cirior (ope	,									
		by PI	Part II. Other significant conditions con	tributing to death b	out not res	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did tol	oacco use c		ne cause of death?			
Vital Records,	law requires as been sign 2 should be										1 🗆 Yı	s 2 No	3 P rob	pably 4 Dunknown			
ecc	elaw n has be ge 2 sh	Completed								_	24a. Was a autops	y I	prior to co	psy findings available mpletion of cause of			
al B	Th ate pag											2 □ No	death? 1 🗌 Yes	2 No			
Z.	Physician; Th this certificate ral director, paç	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{YNo} \)	ospital: 1 Inpatio	0 🗆	ER/Outpatien	t 3□ DO/				Check only on 5 ☐ Reside		Other (Carell				
of	g Phys er this eral dii	H 1	27. Manner of Death	28a. Date of Inju	ıry	28b. Time of		c. Injury	at		d. Describe h			y)			
ion	Attending Ph r death. ector: After th by the funeral	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y rear)	Injury	М	Work?	es 2□No	0							
Division	or At tter of pirection by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, et	jury - At ho tc. <i>(Specif</i>	ome, farm, str	eet, factory,	office		281	f. Location (St City or Town		imber or Rura	I Route Number,			
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin		f examina												
	To the within I	Mec	29b. Signature and title of certifier	•				License				_	ned (Month,				
)	2		15	51	11	>	R	25-	00	0	A	pril 9	ril 9, 2004 DO North Wolfe Street altimore, mo 21287				
(7		30. Name and address of person who co	mpleted cause of o	death (Iten	n 23a) (Type,	Print)				6	00 No	North Wolfe Street				
	0		Robert & Stephens, M	D Johns H	lopkin	Hospit	al Too	ver 110	, Pocto	ws LOI	DNGE [3altim	ore, m	0 21287			
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 1 20	05 32 Aegisti	rar's Signa	ityre	and										

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1	State of Maryland State of Maryland		artmen tificate			and iv		Reg. No	005	1216
	Physicia /Medic	n	1. Decedent's Name (First, Middle, Last) Marie H. Medlock						2. Date of De Month April	7	2 ^{Year} 2005	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number) Stella Maris		Timor	nium	Location of			Bal	unty of Death timore	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. lat 1 M 2 X 93	Yrs.	If Under Months	Days	Hours	Min.	8. Date of Bir (Month, Da Apr. 17	th y, Year) 191	Coul	place (State or Foreign ntry) / land
1	show		Usual Residence of Decedent 10a. State 10b. County 10c. City, MD Baltimore Towso	Town or Lo	ocation						1	10d. Inside City Limits 1 ☐ Yes 2 No
4	a or 28a- Lbe notifi	Direct	10e. Street and Number 902 Locustvale Road		10f. Zip	Code				10g. Citizer	of What Cou	ntry?
5-0036	perim. ragss ranks about 20 Mighen. Transparent in the same that the same transparent in the same tran	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marned 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S Amed Forces? 1 Yes 2 Wildowed 17. Was Decedent Ever in U.S Amed Forces? 1 Yes 2 Wildowed 18. Was Decedent Ever in U.S Amed Forces? 1 Yes 2 Wildowed 19. Was Decedent Ever in U.S Amed Forces?	1	Was Decedif Yes, spec		spanic Ori n, Mexicar Specify:		pecify Yes or No Rican, etc.)		Race - Americ Black, White, pecify: Whi	etc.
1215-0	ne. han "natur	mpleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece (Give life.			ation luring mos	t of work	king	16b. Kind	of Business/Ir	ndustry
Maryland 21215-0036	ental Hygiene. ked other than	To Be Co	17. Father's Name (First, Middle, Last) James Hagan	100	10310	icire.	18. Mothe		Shanaha	, Maiden Su		
Mary	alth and Mental 27 Is marked o	Ĕ	19a. Informant's Name/Relationship (Type, Print) Regina Bressler / cousin	11702	2 Har	ford	Road		ra/Route Numb Glen Arn	n, MD	21057	
Baltimore,	Department of Health Important: If item 27 any injury or other tr		1 Donation 5 Other (Specify)	ce of Disponence of View		etery	/	4/13	B/05	Honea	Path, Vork	SC
Bal	Depar Impor any in		21. Signature Sice trice trice to the signature of the si	Rt	uck To	owsor	n Fun	eral	Home	Tow		D 21204 Approximate
	nysician /Medical Examiner	8 12	23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one/cause on each lite. Immediate Cause (Final disease or condition resulting in death) Due to (and a consequence	46	S)15€	, cr 2	6			Interval Between Onset and Death
760,	le be executed /sician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen									
Box 68	death certifical e attending phy d for use as th	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic p □ Other (s		,			230	d. Date of deliving Month	very Day Year
ds, P.O.	uires that to i signed by Id be detad	by	Part II. Other significant conditions contributing to death but not resu	Iting in the	underlying	cause giv	en in Part	l.			contribute to	the cause of death?
l Recor	The taw requires that the sate has been signed by the page 2 should be detache	Completed							24a. Wa auto pen 1 🗆 Yes	opsy formed?	24b. Were aut prior to c death? 1 \(\sum \text{Yes}	topsy findings available completion of cause of
Division of Vital Records,	Attending Physicien: The death. r death. ector: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 28. Date of Injury (Month, Day Year)	R/Outpatie 28b. Time Injury		28c. Injur Wor	y at	lursing H	tome 5 Res	sidence 6 [eify)
Division	f or Attendin after death. Director: Af I in by the fur	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At ho building, etc. (Specify		M treet, facto		Yes 2]No		(Street and I	Number or Ru	ral Route Number,
_	Hospite 4 hours Funerel ely fillec	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know and manner stated.	wledge, dea ion and/or i	th occurred investigatio	d at the tie	me, date a opinion, de	nd place ath occu	e, and due to thurred at the time	e, date and p	lace, and due	to the cause(s)
)	To the within 2 To the complete	Me	29b. Signature and title of certifier	MD		D S	Se number	74	0	A9d. Date	signed (Month	2005
10	\		30. Name and address of person who completed cause of death (Ifem ERNESTINE A. WRIGHT, M.D.	230	O DUL	ANEY	VALI	LEY	ROAD	TIMON	IUM M	D 21093
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signa	ure	whi							

DHMH 17 Rev 1/2001

11:10 A.M.

APRIL 7, 2005

MEDLOCK, MARIE

			For State	State of Maryla		artment of H <i>tificate of L</i>			2000	10116
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	uncate of t	Jealii	2. Date of Dea	th	3. Time of Death
	Physici /Medic		Dorothy W.	Miller				April '		9:35 p ^M
7	Examin	er	4a. Facility Name (If not institution, give s			414	Location of Death		4c. County of Death	_
_	Formeral		2229 Monkton Ro 5. Social Security Number 6. Sex		rs. last birthday)	Monkton If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Baltimore 9. Birtho	place (State or Foreign
	Funeral Director			M 2 7 F	B1 Yrs.	Months Days	Hours Min.	(Month, Day December	14, 1923 Weshi	ngton, DC
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation			1	0d. Inside City Limits
	Maryis 1 sho	ō	MD Baltimo		Monk					1 ☐ Yes 2X No
	r 28a-	Director	10e. Street and Number			10f. Zip Code		1	log. Citizen of What Cour	ntry?
	th with		2229 Monkton Ro	ad		21111	1		U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 ie marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examilinat must be nullised at once.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 ☑ No	spanic Origin? (Sp n, Mexican, Puerto Specity:	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	2 hour	ed b	15. Decedent's Educ	cation	16a. Deced	dent's Usual Occupa	ation		16b. Kind of Business/In	dustry
215	thin 72 e. en "na Media	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done of OO NOT use retired	fluring most of worl)	king		
	led wil	Con		4	Re	searcher	40 Markada Maria	- (Final Middle	Hospital	
and	d be findal Hed ott	Be o	17. Father's Name (First, Middle, Last) Lawrence	Washing	nton		Dorot		Maiden Sumame) Walke	r
Maryland	shoulk nd Me mark mark	우	19a. Informant's Name/Relationship (Type			g Address (Street a			r, City or Town, State, Zip	
	and 2 alth a 127 le er trai		Frank M. Benson-At	torney	309	Cathedra:	l St., Ba	altimore,	, MD 21201	
ore	of He of He If item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re			natory or other plac	9)		20c. Location - City or To	own, State
altimore,	t. Pag tment tent: ijury o		`4 Donation 5 Other (Specify)	pt.		iscopal Chu			Mankton, MD	
Bal	Depar Depar Impor any ir		21. Signature of Funeral Service License	e milliam G. Da	LI 22	Name and Addres			Funeral Home, 104	inc.
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.			g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	- 1	RTENS					
н	Examiner			Due to (or s a cons	equence of):	ARTE	RY D	isea	SE Yniserue	
		ner	Sequentially list conditions. If any, leading to immediate cause. Enter I Inderlying.	Due to (or as a cons	equence of).				10.0	
	acuted ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CHRONIC	- DR	51KUCI	IVE Ful	worry.	111.75mg	
60,	ficate be executed physician and s the burial-transit	E	resulting in death, cast	Due to (or as a cons	equence or):			•	,	
68760,	ficate physics the	edlcal	d	Devitor	1744				7	
Box	leath certifu attending p	In/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy			23d. Date of delive	
	The law requires that the death certil the has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown		Other (specify)			Month	Day Year
0.	that th		Part II. Other significant conditions con	tributing to death but not r	esulting in the ur	nderlying cause give	en in Part I.	23e. Did tot	bacco use contribute to the	ne cause of death?
ds,	w requires that been signed to should be det	d by			_			LA Ye	es 2 No 3 Prob	ably 4 □Unknown
Records,	aw req as beer 2 shou	olete						24a. Was a	n 24b. Were auto	psy findings available
	The lav	Completed						autops perform	med? death?	npletion of cause of
Vital	yelcien: Th is certificate director, pag	Be (25. Was case referred to medical examiner?	one itali		0.5		th (Check only on	18)	
	is di	- L	1 Yes 2 No	ospital: 1 Inpatient 2 28a. Date of Injury	☐ ER/Outpatien 28b. Time of	t 3□ DOA Othe 28c. Injury	4 Nursing H	_	ence 6 Other (Specify	/)
ou	tending Ph leath. tor: After th the funeral	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		Work	? /es 2 □ No			
Division of	al or Attend after deatl Director: d in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, streetly)	eet, factory, office		28f. Location (St City or Town	reet and Number or Rura n, State)	I Route Number,
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my ker: On the basis of examand manner stated.	nowledge, death ination and/or inv	occurred at the time restigation, in my op	e, date and place, pinion, death occur	and due to the carred at the time, da	ause(s) and manner as st ate and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Month,	Day, Year)
	-		151 14. Kar	MI)		1231	08-6	F	15R. L 8, 2	005
10	01		30 Name and address of person who co	moleted cause of death (II	tem 23a) (Type,	Print) RIVI) Suite =	108.A BA	- Itimone mc	1239
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig		selv	1 10 0	.5- /,(11 1110	0.00 - 1
	Registr	ar	TAK TI 70	UJ SELVE	1- 1-					

			1 - For Stete Registrer	State of M	1arylan		artment o				Reg. N	2005	12147
П	- · · · · · · · · · · · · · · · · · · ·	**	1. Decedent's Name (First, Middle,	ast)						2. Date of De. Month		ay Year	3. Time of Death
	Physicia /Medic		Earl Leroy Moore	.						April	7,	2005	10:55 PM ^M
	Examin		4a. Facility Name (If not institution, g				4b. City, To	wn, or Locati	on of Death		4	c. County of Death	1
			Gilchrist Center					Tow				Baltimore	
	Funeral Director		255-06-0059	. Sex 1 0 M 2 □ F	43	Yrs.	If Under 1 \ Months D	ear If Un Days Hou	der 24 Hrs. rs Min.	8. Date of Bird (Month, Da 04/08	у, Үөа	r) Coi	nplace (State or Foreign untry)
	and *		Usual Residence of Decedent 10a. State 10b. County	-	10c. City	y, Town or Lo	ocation		-				10d. Inside City Limits
	Aaryi f eho	ក	MD Dorche	stor	Soc	retar	.,						1 ☐ Yes 2 No
	the the 28a-	ect	10e. Street and Number	SCEI	560	recar	10f. Zip Co	ode			10g. C	Citizen of What Co	untry?
	with se or	<u>ā</u>	104 Poplar Stree	.+			2166	4			US.	A	
	ns 2:	era	11. Marital Status	12. Was Deceder	nt Ever in U.	S. 13.	Was Deceden	t of Hispanic	Origin? (Spe	cify Yes or No)-	14. Race - Amer	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Intropriant: If them 27 is marked other than "natural; or items 23e or 28e-f ehow any injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1	No		If Yes, specify 1 ☐ Yes 2 ☐	,		Hican, etc.)		Black, White	
5	2 ho	ted	15. Decedent's	Education		16a. Dece	dent's Usual C	occupation	nost of worki	ina	16b.	Kind of Business/I	
	hin 7	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-40	r 5+)	life.	DO NOT use	retired)	nosi oi worki	, ig	Se	lf-Employ	yed
7	d with	Completed	12		,	Hand	yman						
2	othe vent,	Bec	17. Father's Name (First, Middle, La	st)				18. M	other's Name	(First, Middle,	, Maide	en Sumame)	
g	Aenta Aenta rked tic e	ToE	Unknown Moore					Те	resa	Unknown			
<u>a</u>	sho and N s ma		19a. Informant's Name/Relationship	(Type, Print) Fr	iend	19b. Maili	ing Address (S	Street and Nu	mber or Rura	il Route Numb	er, City	or Town, State, Z	lip Code)
Ξ	alth alth 27 1 27 1 sr tra		Mary Jane Franci	s Bennett		73 F	'oxwell	Bend	Road G	len Bu	rni	e, MD 210	061
נו ב	ts 1 and the life months of the		20a. Method of Disposition		1 0	lace of Dispo	osition (Name matory or othe	of ar place)	l .	Apr 11	20c.	Location - City or	Town, State
2	Page ent c nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		(e	-	ke Cre		Inc.	2005	Be	ltsville,	Maryland
	mit. Journal oortal		21. Signature of Euneral Service Lie		40098	2. 2	2. Name and	Address of Fa	acility				
ŏ	permi Depar Impor any ir once.		1 In	ell	===					l Alter Drive			aryland 2128
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caus	ed the death	n. Do not en	ter the mode of	of dying, such	as cardiac o	or respiratory a	rrest,		Approximate Interval Between
١.	Physician		Immediate Cause (Final		reta	· Lal	5-1	d (an	Con	COR			Onset and Death
В	Physician /Medical		disease or condition resulting in death)	a	as a consequ		()	<i>B</i> 0.7.	-/-	-(-1-			VICOTO
	Examiner		1		,	,							
b.		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	as a conseq	uence of):							
	uted Insit	m in	Cause (Disease or injury										
	cate be executed bhysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or a	as a conseq	uence of):							
9	siciar siciar buri	dlcal		d.									
00	ficate p phy s the	edlc											
You .	The law requires that the death certificate be executed tite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3	□Ectopic preg □ Other (spec					23d. Date of deli Month	very Day Year
	nat th d by letac	Phy	Part II. Dther significant condition	s contributing to death	but not res	ulting in the I	inderlying cau	se given in P	art I	23e, Did t	obacco	o use contribute to	the cause of death?
ń	rest signe	by	Tarrin Dillor digitality	- 00g to 200			, g			10	Yes	2 No 3 Pro	obably 4 Unknown
cords,	requi	Completed										<u></u>	
נ	law lasb	nple								24a. Was		prior to d	topsy findings available completion of cause of
=	The	Co								1□ Yes	2 N		2 No
N I G	Physician: The law rithis certificate has brail director, page 2 s.	Be	25. Was case referred to medical examiner?						lace of Death	(Check only o	one)		
5	hysi his c Il dire	မ	1 ☐ Yes 2 No	Hospital: 1 🗆 Inpa			nt 3 DOA			me 5 Resi			ity) Hospice
<i>-</i>	ng P	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Ir (Month, I	njury Day Year)	28b. Time o Injury		. Injury at Work?		28d. Describe	now in	jury occurred	
	endi eath. or: A he fu	catl	2 ☐ Accident investiga	t ho			М	1 Tyes					
Ĕ	or Att ter de irect n by t	ertification:	3 Suicide 6 Could no 4 Homicide determin	286. Flace UI	Injury - At ho etc. <i>(Specif</i>	ome, farm, st y)	treet, factory, o	office		28f. Location (City or To	Street wn, Sta	and Number or Ru ate)	rai Houte Number,
2	ital o	0											
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page	ledical	(Check only 2 Medicel E.	Physician: To the be kaminer: On the basis and manner	of examina	wiedge, dea tion and/or in	nvestigation, in	my opinion,	death occurr	and due to the red at the time,	date a	ind place, and due	to the cause(s)
	To I To I	Σ	29b. Signature and title of certifier	1-1	7			icense numb			-	Date signed (Month	
			1/ Anth	my Mil	700	On	100	252	07		17.	pril 8,	2003
	1		30. Name and address of person w	no completed cause of	death (Iten	n 23a) (Type	, Print)	11/	-1	e. C.	6	04.	2005 nd 212gx
			W.A.R.l	27 6	Din ((0/01	N. C	no	The JA	F	DENCE OF . V	na 21 292
		ato	31. Date filed (Month, Day, Year)	/ 32 Rogi	strar's Signa	ture							

Registrar

APR 1 1 2005 Been & Spelle

Moore, Earl

			State of Maryland / Departing State	ment of Health and Molicate of Death		ene 005	12148
Ī	Physicia		1. Decedent's Name (First, Middle, Last) ROSS F. Mills		2. Date of Death Apr 11	07 2 00 5	3. Time of Death 2:40 P M
	/Medic Examin		Tall admity frame (in the members) give on data and the members	o. City, Town, or Location of Death estminster MD 211	57	4c. County of Death	
	Funeral Director			Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Y 2/25/194	9. Birth <i>Cou</i>	place (State or Foreign intry) 1D
	ryland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	h the Ma rr 28a-f e notifies	Director	TID CUITOIT	ninster 10f. Zip Code	10g	. Citizen of What Cou	
	23a o	ra D	1211 Bloom Road	21157		USA 14. Race - Amer	inna Indian
0	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. Health and Mental Hygiene. To smarked other than "natural", or Items 23a or 28a-f show there 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinat must be notified at	by Funeral	Armed Forces? If Ye 1 □ Never Married 20 Married 10 Yes 2 □ No	s Decedent of Hispanic Origin? (Spe es, specify Cuban, Mexican, Puerto F Yes 2 ሺ No Specify:	city Yes or No- Rican, etc.)	Black, White	, etc.
0-0-	in 72 hour n "natural Aedical E	Completed b	15. Decedent's Education (Specify only highest grade completed) (Give kim life, DO	t's Usual Occupation d of work done during most of workir NOT use retired)	16	Sb. Kind of Business/l	ndustry
717	od with giene. er ther	Som	Elementary/Secondary (0·12) College (1-4or 5+) 4 Inst	urance Agent		Insurance	e
2	uld be file fental Hy rked oth	To Be (17. Father's Name (First, Middle, Last) Roy Mills	18. Mother's Name	, -,	•	
	d 2 th a tra		Tod. (Inciliated Harrist Indianos Inc.)	Address <i>(Street and Number or Rur</i> a loom Road Westmir		•	p Code)
เ	Pages 1 ar nent of Hea ant: if Itam 3 ary or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Crestlawn			oc. Location - City or Tarriottsv	
Dallillor	permit. Pages 1 an Department of Heal important: if Itam 2 any injury or other once.		21. Signatura of Funeral Service Licensée HAT	ame and Address of Facility GHT FUNERAL HOME esville, MD 21784	& CHAPEI	L. PA (Box	195)
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter to shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Approximate Interval Between Onset and Death 8 Months
,00,0	certificate be executed nding physician and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
0	ath certific attending p for use as	Physician/Med		etopic pregnancy ther (specify)		23d. Date of deli Month	very Day Year
	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the under	orlying cause given in Part I.		cco use contribute to	the cause of death?
Records	has has	Completed			24a. Was an autopsy perform	ed? death?	topsy findings available ompletion of cause of
N I G	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
<u></u>	Jing Phys I. After this funeral di	tlon: To	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	3 DOA Other: 4 Nursing Hor 28c. Injury at Work? M 1 Yes 2 No	ne 5 X Residen 28d. Describe how		ify)
UNISION	or Attender ter deatlinector:	Certificati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, lactory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
_	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death or 2 Madical Examiner: On the basis of examination and/or inves and manner stated.	ccurred at the time, date and place, a stigation, in my opinion, death occurred	and due to the cau ed at the time, dat	use(s) and manner as se and place, and due	stated. to the cause(s)
	Mithin 7	Med	29b. Signature and title of certifier	29c. License number		d. Date signed (Monti	
	9		In SX / Noth-MC	D0024532		April 08,	2005
1	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri University of MD, Greenebaum Cancer Cen	ter 22 S. Greene	, M.D. St. Bal	timore, MD	21201-1595
İ	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature A PR 1 1 2005				

		-	State of Maryland / State of Maryland /	Depa		t of H	ealth a		ental Hygi	ene g. No. 2005	12149
	Physicia /Medic Examin	in al	1. Decedent's Name (First, Middle, Last) Florence N. Miles 4a. Facility Name (If not institution, give street and number)		4b. City,	Town, or	Location o		2. Date of Death Month	Day O Year	
I	Funeral Director		Manor Care Ruxton 5. Social Security Number $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	irthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. 8 Min.	B. Date of Birth (Month, Day, Jan 19,	Baltime 9. Bi 1915 Mar	ore thplace (State or Foreign ountry) yland
	Maryland a-1 show	ctor	Usual Residence of Decedent	m or Lo							10d. Inside City Limits 1 ☐ Yes 21 No
15-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show he Medical Examiner out be multified at	Completed by Funeral Director	(Specify only highest grade completed)	a Dece	Was Decedif Yes, specific Yes :	dent of Hi city Cuba 2 X No	Specify:		ify Yes or No- ican, etc.)	g. Citizen of What C USA 14. Race - Am Black, Wh Specify: W	erican Indian, te, etc. hite
rland 212	be filed ntal Hygi od other event, I	To Be Comp	Elementary/Secondary (0-12) Callege (1-4or 5+) 17. Father's Name (First, Middle, Last) Elmer Stambaugh	E	execut	ive	18. Mothe	r's Name (First, Middle, M	taiden Sumame) nnson	Dept Store
Baltimore, Maryland 21215-0036	1 and 2 sho Health and Iem 27 Ie m		Daisy Gagliano/sister 8	3616 of Dispo	B1ac	k Oa	k Roa		ltimore	City or Town, State, MD 21234	
Baltin	permit. Pages Department of Importent: If II any Injury or once.		21. Signature of Euneral Struce Licensee Ronald S. Wade, Director	B	altim	ore,	MD	21201		Baltimore	
	Medical Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a conseque				EAN	1				St,	Approximate Interval Between Onset and Death
x 68760,	eath certificate be executed attending physician and for use as the burial-transit	cai	that initiated events resulting in death) Last Due to (or as a consequence d. IF FEMALE: 23c. If yes, outcome of pregnancy							23d. Date of d	alivery
P.O. Box	t the du by the ached	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5(⊒Ectopic pi ⊒ Other (sp	pecify)				Month	Day Year
	w requires that been signed is should be det	Completed by F	Part II. Other significant conditions contributing to death but not resulting		inderlying o	ause give	en in Part I.		1 ☐ Ye	s 2 16 3 1	to the cause of death? Probably 4 Unknown autopsy findings available
Vital Records,	yeiclen: The law is certificate has t director, page 2 s	a	AMUAL FIBFILLATION DEMENTA 25. Was case referred to medical				26. Place	of Death	autopsy	prior to death?	completion of cause of
Division of Vi	ling Ph I. After th Iuneral	Certification: To B	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury (Month, Day Year) 28b. Date of Injury (Month, Day Year) 28b. Place of Injury 28b.	. Time o	М	28c. Injun Wor	4-1 NU	No 21	8d. Describe ho	nce 6 Other (Sp. w injury occurred	
Div	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the		4 ☐ Homicide building, etc. (Specify) 29a. Certifier 1 ☐ Certifying Physician: To the best of my knowled	ge, dear	th occurred	at the tin	cinion don	th accurre	d at the time do	use(s) and manner	as stated.
	To the Ho within 24. To the Fu completel	Medical	29b. Signature and title of certifier	arity OF IF	29	c. Licens	e number	0	29	9d. Date signed (Mo	
	Sta		30. Name and address of person the completed cause of death (Item 23a WATTER HEPVEIL 5925 Cytra.) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	(Type	Print)	- (HyDi	7, L	2 91	1082	
	Registi	ar	APR 1 1 2005 Bear 15	57.0							

			State of Maryland / Depart		ntal Hygien	2005 10170
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	ficate of Death	Reg. N	3. Time of Death
	Physicia		il Oalachy	,		2005 /1 48 P M
	/Medic Examin			b. City, Town, or Location of Death	4	4c. County of Death
	Examili	eı	Harbor Hospital Center	Baltimore		NIA
	Funeral		Social Security Number 6. Sex 7. Age (In yrs, last birthday)	If Under 1 Year If Under 24 Hrs. 8. If Under 1 Year Hours Min.	Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
	Director		251-30-0831 PM 24 Yrs.	A	Month, Day, Yea	920 SOUTH CAROLINA
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	tion		10d. Inside City Limits
	Mary 1 sh	to	MARYLAND N/A	BALTIMORE	CIT	1 ☐Yes 2 ☐ No
	n the	Directo	10e. Street and Number	10f. Zip Code	109/0	Citizen of What Country?
	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28e-f show ta Musical Everili art wat Le mullind at		604 KOUNDVIEW ROAD	2122	5	USA.
	ltems	Funerai		s Decedent of Hispanic Origin? (Specify 'es, specify Cuban, Mexican, Puerto Rica	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.
36	rs afte	by F	1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No If Yes, Give 1 □ S ☑ Widowed 4 □ Divorced Year or Dates:	Yes 2 No Specify:		Specify: BI ACK
5-003	2 hou	ted	15. Decedent's Education 16a. Deceder	nt's Usual Occupation	16b.	Kind of Business/Industry
215	thin 7	ηpie	Flementary/Secondary (0-12) College (1-4or 5+)	nd of work done during most of working NOT use retired)		
7	filed with Hygiene. other than	Completed	101	PERVISOR		OMRD OF ADVISORS
Maryland	be fill hall Hall Hall Hall hall hall hall ha	Be	17. Father's Name (First, Middle, Last)			en Sumame) (MN - UN KNOW)
$\frac{3}{2}$	should be nd Mental marked c	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rural Ro		v or Town. State, Zip Code)
S S	od 2 Ith a 27 ls		SONDRA BROOKER (DAUGHTER) 438	W. WOSDLAWNS		- 1116
ē,	ges 1 ar t of Hea If itam or other		20a. Method of Disposition 20b. Place of Disposition			Location - City or Town, State
more,	0		Burial 2 I Cremation 3 I Removal from State	SCEMETERY 04-14	1-05 AK	RBUTUS, MARILAND
a	permit. Pag Department Important: I any Injury o			Name and Address of Facility,	ROWN	JR, FUNERAL HOME
<u> </u>	89589		which N. Williams &	140 N. FULTON	AVE.K	PALTO, MD. 21211
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac or re-	spiratory afrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition			one day
-	/Medical Examiner		resulting in death) Due to (or as a consequence of):	1		
		-	Sequentially list conditions, if any, leading to immediate b. House to (or as a consequence of):	lure		one day
	uted 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c,			
oʻ	sician and burial-transit	Еха	resulting in death) Last Due to (or as a consequence of):			
8760	ate be executed hysician and the burial-transit	dicai	d			
9		Med	IF FEMALE:			
Box	ath ce attend for us	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome or pregnancy 1 Live birth 2 Fetal death 3 E	ctopic pregnancy		23d. Date of delivery Month Day Year
P.0.	that the de led by the a detached f	Physician/Me	1 Tes 2 No 4 Pregnant at time of death 5 C 9 Unknown	Other (specify)		
	The law requires that the death cedificate has been signed by the attending page 2 should be detached for use as	y Ph	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
rds	quires n sign	d by	Hypertension		1 Tes	2 ☐ No 3 ☐ Probably 4 X Unknown
00	aw require s been sig 2 should t	Completed	Hypertension Diabetes Mellitus		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ	The taw ate has page 2 s	E O			performed?	? death?
ita	ctor, I	Be C	25. Was case referred to medical examiner?	26. Place of Death (C		
<u>></u>	hyslo this co	၉	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient			6 ☐Other (Specify)
ב	ling F	ion:	27. Manner of Death 1 X Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	28c. Injury at Work? M 1 Yes 2 No	. Describe how in	jury occurred
Division of Vital Records,	death ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree		Location (Street	and Number or Rural Route Number,
<u>S</u>	after after Dira	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Sta	16)
	pspits hours unera y fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of			
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medicai	(Check only 2 Medical Examiner: On the basis of examination and/or inveone) and manner stated.			
	To To E	Σ	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
•	2	1	- Internal Medicine Intern	1/62000	. Ap	ril,7, 2005
)		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	61	my	2/225
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatus	our gry pointinois	, IIIG.	134 1 340Km
	Regist		APR 1 1 2005 Mars			

	e istrar	State of Maryland	/ Depa		lealth and	Mental Hyg	giene Reg. No. 2	005	12151
Physician Nel	dent's Name (First, Middle, Last) Lie ty Name (If not institution, give st	Mae	Pri		r Location of Deal		OS 4c. Cor	Year 2005 unty of Death	3. Time of Death
Funeral 5. Social 230-	10-3000	cy Medical Cent 7. Age (In yrs. las M 2 N F 99		Baltin If Under 1 Year Months Days				9. Birthp Coun	lace (State or Foreign try) VA.
0	N/A		Town or Lo	more			10c Citizen		0d. Inside City Limits 1 XYes 2 □ No
11. Marita	Pet and Number Dillon Street al Status Never Married 2 Married Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1		10f. Zip Code 2' Was Decedent of Fif Yes, specify Cubin 1 Yes X No			US	Race - Americ Black, White,	an Indian,
d within 72 giene. The Malic Complete	15. Decedent's Educ (Specify only highest grade intary/Secondary (0-12)	ation	(Give life.	dent's Usual Occup kind of work done DO NOT use retired tory Wor	during most of wo d) KET		Packi	of Business/Ind	
Paga i C Jame	er's Name (First, Middle, Last) es Deane ormant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street	Susie 1	me (First, Middle, Mae Leona ural Route Numbe	ard		Code)
Trian 200 Mot	lis L. Swain	daughter	3107 ce of Dispo	Dillon Station (Name of matory or other plan	reet, Ba	altimore, il ^{nate} 12,	MD. 2	1224 on - City or To	wn, State
Paritiment A D	Donation 5 Other (Specify)	Mead		ge Cemete Onnelly 1 110 Solle		000		k,P.A.	MD. 21222
Immedia disease	rft. Enter the disease, or compliceck, or heart failure. List only one ate Cause (Final or condition g in death)	e cause on each line.	Do not ent احرارک		ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
exe Sering Lesuiting	tially list conditions, bading to immediate Enter Underlying Disease or injury ated events c.	Due to (or as a conseque	,						
ath certification of use as the certification of use as the same of us	ALE: us decedent pregnant he past 12 months? Ves 25 No	ic. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea	eath 3	Ectopic pregnance	1		23d.	Date of delive Month	ory Day Year
w requires that the de been signed by the a should be detached feted by Physic et al.	ther significant conditions cont	ributing to death but not result	ing in the u	nderlying cause giv	ren in Part I.				ably 4 Unknown
0 T ()						1 ☐ Yes	sy rmed? 2 No	4b. Were auto prior to cor death? 1 Yes	psy findings available npletion of cause of 2 No
Physical Physics Physi	ner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	M 1	er: 4 \sum Nursing I	ath (Check only of Home 5 Aesid 28d. Describe h	lence 6 🗹	ccurred	, , , , , ,
To the Hospitel or Attending within 24 hours after death of the Funerel Direct death o	Homicide determined rtifier 1 ☑ Certifying Physi	28e. Place of Injury - At hom building, etc. (Specify)	ledge, deatl	n occurred at the til	me, date and plac	28f. Location (S City or Tow e, and due to the	m, State) cause(s) and	manner as st	ated.
To the Hospitel or within 24 hours aft. To the Funerel Bit completely filled in completely filled in Medical Cer. Medical Cer. Sign 9.0 9.0 9.0 9.0 9.0 9.0 9.0 9.0 9.0 9.0	nature and title of certifier	er: On the basis of examination and manner stated.	n and/or in	29c. Licens			29d. Date si	gned (Month,	Day, Year)
le E	e and address of person who cor	mpleted cause of death (Item 2 301 ST 3 Registrar's Signary	Pal		altimo	re mo	<u>.</u>	2120	2

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April DONALD PAIIT. 2005 RIDER 3:25 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick
If Under 1 Year | If Under 24 Hrs. Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1XM 2□F Hours Director 232-56-5783 Sept. 17, 1936 West Virginia Usual Residence of Decedent death with the Maryland Show 10a. State 10b. County 10c. City. Town or Location r then "natural", or Itams 23a or 28a-f show the Modical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27525 Ridge Road Funerai Damascus United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 1953-59 Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 Is marked other then "natural", or Ita 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: 3 Widowed 4 Divorced White Be Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Insulation Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 James Rider Mary Brady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby D. Rider/ Wife 27525 Ridge Road, Damascus, Maryland 20872 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Park 4/11/2005 Frederick , Maryland 21. Signature Juneral Service Licensee Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MyoumpiAI Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner (OION MY Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 donknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year) L. D0061112 M./J. 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) RUNNIE L. Jreshs M.O. Frelerick Hosp. Ful 32. a gistrar's Signature 31. Date filed (Month, Day, Year) State APR 11 2005 Registrar

			1 - For State Registrar	State of N	Maryland / De	epartment of Certificate	of Health	and M	ental Hyg	giene Reg. No. 20	05	12	153
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2-0	be filed within 72 hours after death with the Maryland hal Hygiene. Indother then "naturel", or Items 23a or 28a-f show event, I're Medical Evaluate must be notified at	Completed	15. Decedent' (Specify only highest	s Education grade completed)	(0	ecedent's Usual (Give kind of work	done during m	ost of workii	ng	16b. Kind of Bu	siness/In	dustry	
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687	3 × 5			d									
×	death certiticat e attending phy id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco						23d. Date	of deliv	ery	
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٣	de de	by Pt	Part II. Other significant conditio	ns contributing to deat	th but not resulting in t	he underlying cau	ise given in Pai	rt I.	23e. Did to	obacco use contr	ibute to t	he cause of c	leath?
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Division	ial or Attendii s atter death. sì Director: A ad in by the fu	ific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	286. Place of	f Injury - At home, farr	n, street, factory,	office		28f. Location (S City or Tox	Street and Number	er or Run	al Route Num	ber,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death APRIL Yeer **Physician** ROCHKIND 2:40 PM STANLE 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner to SPITAL NORTH WEST Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex XıXIM 2□ F **Funeral** 215-28-7960 72 Sep. 11,1932 Director Maryland Usuel Residence of Decedent filed withIn 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits If Item 27 is marked other than "natural", or Items 23a or 28e-f show or other treumetic event, the Madical Examiner must be notified at XXYes 2 No MD Baltimore Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3211 Clarks Lane Apt. 416 21215 U.S.A. 12. Was Decedent Ever in U.S.
Amped Forces?
XXves 2 \sum No
If Yes, Give Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White If Yes, Give Year or Dates: 3 Widowed XXDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Heavy Equipment Operator Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Milton Rochkind Clara Shapiro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if item 27 Kenneth S. Rochkind / Son 409 Dyer Ave. Reisterstown, MD 21136 20a. Method of Disposition
1 ☐ Burial 2XX remation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department o Importent: If any injury or once. 4/11/05 Metro Crematory Inc. Baltimore, MD 4 □Donation 5 ☑ Other (Specify) 21. Signature of Fone al Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION **Physician** ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by PHECHONIA 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has funeral director, page 2 autopsy performed' After this certificate 2√2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 PNo 1 Inpatient Medical Certification; To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No nours after death.

nerel Director: A investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 243 ZZ 2005 APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TODOR MIRCEA JATI 920H RANDAUSTOWN MD 21133 TZ 3 W HTJON 5401 OLD COURT ROAD 31. Date filed (Month, Day, Year) 22. Registrar's Signature State APR 1 1 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death B. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 9:00PM (Francesco) L. Schiano APRI 2005 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a BALTIMORE GOOD SAMARITAN HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠**M 2□F 75 217-34-4228 Director 8-3-1929 Naples Italy Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County ahow traumatic evant, the Mudical Examinar must be notified at MD Baltimore Towson 1 Yes 2 No Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2903 Rueckert Avenue 21204 USA 238 Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 □ Never Married 2 □ Married Specify: WHITE 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Setter Acme Tile Elementary/Secondary (0-12) College (1-4or 5+) Marble-Tile Terrazzo 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Teresa Lavadera Amedeo Schiano 19a. Informant's Name/Relationship (Type, Print) daughter 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is n any injury or other traun once. 3403 Clark's Lane, Baltimore, MD 21215 Teresa Dutton 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/8/2005 Baltimore, MD Greenmount * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N.21. Signature of Funeral Service Licenses Zannino Jr. FH timore, MD 21224 263 S. Conkling St., Baltimore, connecto 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OPD Excacerbation disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or highly that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit Due to (or as a consequence of): attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No Probably 4 Unknown CORONARY ARTERY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 12 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After Hospital or Attending Natural after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 0 P15306 04106105 neted cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL 30. Name and address of perso

Registrar

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31. Date filed (Month, Day, Year)

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14. Year) 20. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No:-2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer **Physician** 11:11 PM M 2005 April George W. Sparks, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nottingham

If Under 1 Year | If Under 24 Hrs. | 8

Months | Days | Hours | Min. | 3911 Mewswood Lane, #A2 Baltimore 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Yrs. 72 Director 02/21/1933 MD 212-30-3421 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d, Inside City Limits 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Mutical Exerting must be nutitled at 10a. State 10b. County 1 Yes 2 No Director Nottingham Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code United States Funeral 3911 Mewswood Lane, #A2 2. Mas Decedent Ever in U.S. Amed Forces? 1 Dives 2 □ No If ves, Give Year or Dates: 1951-1953 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Transportation and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) <u>Cab Driver</u> or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Otillia Tuttle George W. Sparks, Sr. ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edith Sparks / Wife 3911 Mewswood Lane, #A2 Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page Department of Important: If any injury or 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Apr 9 4 □Donation 5 □ Other (Specify) Beltsville, Maryland 2005 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility U8Poun Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE 5 YRS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC HEART DISEASE 10 YRS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ig physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Year jo in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 **X**No Hospital or Attending Phyaician: 26. Place of Death (Check only one) neral Diractor: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 7, 2005 D17728 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21236 Baltimore, MD 8022 Belair Rd. Yin Oung, M.D. 31. Date liled (Month 1 2005 2. Registrar's Signature R 1 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 2005 **Physician** Kathleen Mary Ashby Streaker 8:45pm M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Eldersburg Carroll 2255 Mallard Pond Drive 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 43 Yrs Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 145-40-6938 NJ 15 1961 Director Usual Residence of Decedent death with the Maryland 10a. State Md 10d. Inside City Limits 10b. County 10c. City, Town or Location or Items 23a or 28e-f ehow the Medical Examination must be notified at **Eldersburg** Carroll 1 ☐ Yes 2 ☑ No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21784 2255 mallard Pond Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: white Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Al Hygiene. Elementary/Secondary (0-12) health care College (1-4or 5+) cardiac technician other treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Is marked of Patricia Davis Charles Ashby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2255 Mallard Pond Dr., Eldersburg, Md 21784 19a. Informant's Name/Relationship (Type, Print) Mr Charles Ashby (father) t of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department of Importent: If any injury or once. 4-12-05 Marriottsville, Md Mt. View Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Daige Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final metasta-ic non - Smell Can les monetis **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Yo
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? 2 No 1 ☐ Yes 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 2 2 No 5 Residence 6 □Other (Specify) 1 🗌 Yes 28c. Injury at Work? 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death, 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registra 2005

			For State Registrar	State of Maryla	•	artment of H		_	giene 0 (15	2159
	Divisio		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
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	Funeral Director		216-36-7602	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da Oct.	y, Year)	9. Birthplac Country Maryl	,
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d.	. Inside City Limits
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9	or Ite	by Funeral	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2€ No If Yes, Give		1 ☐ Yes 2 ☐XNo		rican, etc.)		ck, White, etc	; .
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	. 6		30. Name and address of person who co.	mpleted cause of death (Item 23a) (Type				-101		
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			1 - For State Registrar	State	of Maryla		artment of H	lealth and N Death		giene leg. No.2005	12160
			Decedent's Name (First, Middle, La	st)		-			2. Date of Dea	th Day Year	3. Time of Death
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	Funeral Director			Sex 1□M 20X[F	7. Age (in y/s	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Oct 3,		rthplace (State or Foreign Country)
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Baltimore,	permit. Pages Department of t Important: If it any injury or o				Directs	MICH D.	/. ·			Baltimore	Street
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ROX	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of preg		Ectopic pregnancy	,		23d. Date of d	
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			30. Name and address of person who	completed ca	use of death (It	ет 23а) (Туре,	Print) GY	AN C	SURY	NA	
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ORIGINAL

			1- For State of Maryland / D	epartment of I Certificate of		and Me		giene Reg. No2	005	12161
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	/Medic	al	ROY 4a. Facility Name (If not institution, give street and number)	SEIDEL 4b. City, Town,	or Location of		APRIL		ounty of Dea	1:20 A M
	Examin	er	CONTINUUM CARE OF SYKESVILLE		SYKI	ESVIL	LE			CARROLL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 7. Age (In yrs	nday) If Under 1 Year Months Days		24 Hrs. 8 Min.	8. Date of Bird Month, Da JAN.5	th 636	9. Bir	thplace (State or Foreign ountry) MD
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	3a or	ij	232 TEAPOT COURT	101. 2.0	2113	36		3		USA
	ams 2	ınera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cut	Hispanic Ori ban, Mexicar	gin? (Spec	cify Yes or No lican, etc.)	- 14	1. Race - Am Black, Whi	erican Indian, te, etc.
2	be filed within 72 hours after death with the Maryland Hygiene. d othar than "natural", or items 23a or 28a-f show event, the Moulest Exact free mount be notified at	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 ሺ No If Yes, Give 3 ሺ Widowed 4 □ Divorced Year or Dates:	1 □ Yes 2 🂢 No	Specify:			S	Specify:	WHITE
3	2 hou		15 Decedent's Education 16a	Decedent's Usual Occu (Give kind of work done	pation	t of working	a	16b. Kind	d of Business	/Industry
7	vithin 7	Completed	Flamestan/Concenten/ (0.12) College (1.4or F.)	life. DO NOT use retire	ed)		,	PROD	UCE ST	TORE
7	filed v Hygie Sthar t	e Co	17. Father's Name (First, Middle, Last)	W.OLK	18. Mothe	er's Name	(First, Middle,			
0	should be filed within od Mental Hygiene. markad othar than imatic event, I've M	To B	PHILIP SE	EIDEL	AN	NA				(UNKNOWN)
aly	2 g is 2			Mailing Address (Stree						
ב ע	t and Health am 27 thar t		20b. Place of	32 TEAPOT C			SIEKSI ite			r Town, State
	Pages ent of nt: If it		1 X Burial 2 Cremation 3 Removal from State	y, crematory or other pla KODESH BETH		EL 4/	8/2005	В	ALTIMO	DRE, MD
0011	permit. I Departm Importal any inju		21. Signature of Funeral Service Licensee	22. Name and Addr	ess of Facili	y SOL	LEVIN	SON &	BROS.	, INC.
0	89 E 29		Day 5 Mark State of the Location of the death Too						VILLE.	MD 21208 Approximate
	**		23a. Part1. Enter the dilease, or complications that caused the death. Do n shock, of heart fayure. List only one cause on each line. Immediate Cause (Final		ing, such as	cardiac or	roopilatory a	11001,		Interval Between Onset and Death
	Physician /Medical		disease of condition resulting in death) Due to (or as a consequence of the condition of t	of):						
	Examiner		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence or	hegra						
	ted nsit	Examiner	Cause. Enter Underlying Cause (Disease or injury							
ĵ	execu an and rial-tra		that initiated events c. Due to (or as a consequence of	3): MA						
00/0	cate be executed physician and the burial-transit	llcal	(I D D	14						
Ď X O	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			_		23	3d. Date of de	elivery
<u>.</u>	death e atter	iciar	1	3 □Ectopic pregnant 5 □ Other (specify)	су				Month	Day Year
5	at the	Phys	9 Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause o	uven in Part I		23a Did t	obacco us	e contribute :	to the cause of death?
ď,	w requires that the de been signed by the should be detached	d by	Hy haalburg	the underlying cause g	in on in a dit	•		Yes 2□		robably 4 DURKnown
corus,	s been shoul	ompleted	1 () ()				24a. Was		24b. Were a	utopsy findings available completion of cause of
ř	The ate h	Comp					auto perfo 1 ☐ Yes	ormed?	death?	
[a	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		ther		(Check only			
5	Phys this al dii	on; To	27. Manner of Death 28a. Date of Injury 28b. T	ime of 28c. Inju	4	drsing Hom	ie 5∐Resi 8d. Describe		Other (Sp.	ecify)
VISION	Attanding F death. ctor: After y the funer	atlo	2 Accident investigation		Yes 2	No		. <u>.</u>		
212	a -	ertificat	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	Э	2	8f. Location (City or To		Number or F	Rural Route Number,
7	To the Hospital or Attand within 24 hours after death To tha Funeral Director: completely filled in by the	O	29a. Certifier 1 Certifying Physicien: To the best of my knowledge	, death occurred at the	time, date ar	nd place, a	nd due to the	cause(s) a	and manner a	as stated.
	To the Howithin 24 h	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination and manner stated.	d/or investigation, in my	opinion, dea	ath occurre	d at the time,			
	To t To t	Σ	29b. Signature and title of certifier		nse number	TU 2	(0			nth, Day, Year)
, 1	<		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	005	72	-12	07	-0'	1-00
2	V		DR. Raman B Keineve	349 Ma	lca (n	4 de	Line, l	Nest!	hierte	7-05 = MD 2/150
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ande						
	Registi	ar	ALK II TOOD TOO							

			State of N	Maryland / Department of Health and M Certificate of Death	lental Hygien	e
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No.	o. 3. Time of Death 0
	Physici		Michalle	Tabbs	April D	
	/Medic Examin		4a. Facility Name (If not institution, give street and number		11711	c. County of Death
1			9 Richman Road ay	OH. H OWINGS MIL		BALTIMORE
	Funeral		TH OFF	Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year 10-3-52	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	92 tis.	10-3-52	TYID
	yland Now		10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
	Man	tor	MARYLAND BALTIMORE	OWINGS MI	445	1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	ath w		4 RICHMAR RD.	APTH 2/11		USA.
	er de	Funeral	11. Marital Status 12. Was Deceded Armed Force 1 ★ Never Married 2 Married 1 □ Yes 2	s? If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc.
336	or, or	by F	3 Widowed 4 Divorced Year or Date	1 ☐ Yes 2 ☑No Specify:		Specify: BLACK
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or liems 23a or 28a-f show the Madical Everting must be notified at	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	16b. I	Kind of Business/Industry
21	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4c	r 5+) life. DO NOT use retired)		and the ser
	be filed within 72 ho ital Hygiene. id other than "netui event, Ire Modes		17. Father's Name (First, Middle, Last)	NURSING 18 Mother's Name	e (First, Middle, Maide	1R5ING HOME
and	should be filed withir of Mental Hygiene. marked other than matic event, the Mi	Be c	MORRIS L.	TABBS MAMI	E /	BAILEY
Maryland		2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura	al Route Number, City	
_	10 27 11 27 11 tre		ASHLEY VON HENDRICKS (DAWS	20b. Place of Disposition (Name of	E, BALTII	YORE, MD. 21215
altimore,	of Hea		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from Sta	cemetery, crematory or other place)		
Ĕ	Pag nent int: I		'4 □Donation 5 □Other (Specify)	METRO CREMATORY 04-1 22. Name and Address Facility	1-05 13	ALTIMORE, MD.
Balt	permit. Pag Depertment Important: any Injury conce.		21. Signature of Funeral Service Licensee	Mains Joseph H. Brown, Jr	Balfil	nore, Marging 21217
	40260		23a Part Enter the disease or complications that cause			Approximate
			shock, or heart failure. List only one cause on each	ed the death. Do not enter the mode of dying, such as cardiac line.	or respiratory arrest,	Interval Between Onset and Death
	Physician /Medical		disease or condition a	as a consequence of):	au in-	arellon
	Examiner		1.	11 pulsusean		
	P ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Either Urder Hybry Cause (Disease or injury	as consequence of):		
	ecute and -trans	Exam	that initiated events .	as a consequence of);		
8760,	ate be executed hysician and the burial-transit		528 (5) (6)	as a consequence or).		
687	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	edical	d			
Вох	eath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	ne of pregnancy 2 □ Fetal death 3 □Ectopic pregnancy		23d. Date of delivery
	death	Physician/M	In the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnan	at time of death 5 Other (specify)		Month Day Year
P.0	that the de ed by the detached	Phy	9 Unknown		22a Did tabassa	use contribute to the cause of death?
S,	ires the signed I be de	by	Part II. Other significant conditions contributing to deat	i but not resulting in the underlying cause given in Part I.		No 3 Probably 4 Unknown
ecords	w require been signature	Completed			24a. Was an	
Rec	has l	mp			autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital	(0 -	e Co	25. Was case referred to medical	26 Place of Deat	1 ☐ Yes 2 ☐ N h (Check only one)	o 1 Tes 2 No
i N	Physicien: this certific ral director,	o B	examiner? 1 Yes 2 No Hospital: 1 Inp	Other		6 ☐Other (Specify)
lof		T :uc	27. Manner of Death 28a. Date of 1 (Month,		28d. Describe how inju	
Sio	Attending r death. ector: After by the fune	catic	2 Accident investigation	M 1 Yes 2 No		
Division	l or Attendater deati	Certification:	3 Suicide 6 Could not be determined 28e. Place of building.	Injury - At home, farm, street, factory, office etc. (Specify)	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospitel or within 24 hours after To the Funeral Direction of th		29a. Certifying Physician: To the be	st of my knowledge, death occurred at the time, date and place,	and due to the cause(s) and manner as stated
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical		of examination and/or investigation, in my opinion, death occurr		
	To the To the To the To the Comple	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
			1. Kaloa Pr	- Das112	4	11 2005
	.7		30. Name and address of person who completed cause of	f death (Item 23a) (Type, Print) Dri We	Suice 101	Ourngs Hells
)					HD24117
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 1 2005	strar's Signature		

		-	State of Maryland / [State Registrar		rtment of H tificate of L		Mental Hy	giene Reg. No	GUU.	12163
			Decedent's Name (First, Middle, Last)				2. Date of De	eath Da	v Year	3. Time of Death
	Physicia /Medic		Jennie O. Tirimacco					8, 2	005	10:15 A M
}	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat	h	40	. County of Dear	h
			Gilchrist Center			Towson	,		<u>Balti</u>	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir		Months Days	If Under 24 Hrs. Hours Min.	(Month, D	rth ay, Year)	9. Birt	hplace (State or Foreign nuntry)
	Director	-	1/8-09-528/ 88	Yrs.			Sept.	/, 1	916 Pen	nsýlvania
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	wn or Loc	ation					10d. Inside City Limits
	Mary	ō	Md. Baltimore		Timon	ium				1 ☐ Yes 2 X No
	28a	Directo	10e. Street and Number		10f. Zip Code	T GIII		10g. Ci	tizen of What Co	ountry?
	3a or	₫	2308 Wuthering Road			21093			USA	
	deatl	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S	Specify Yes or Note Rican, etc.)	0-	14. Race - Ame Black, Whit	
9	or its		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XXNo		☐ Yes 2 XNo	Specify:				White
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural, or itams 23a or 28a-f show ther the Mudical Examinar must be confilled at	d by	34LXWidowed 4 □ Divorced Year or Dates:	- Daniel	anda Haval Occup	ation		1ch k	(ind of Business	
5	"nat	ete	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occup kind of work done o OO NOT use retired	during most of wo	rking	100. 1	(ind of positioss	moustry
12	withi	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Homemake	r			Own Hom	e
D	illed Hyg other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle	, Maidei	n Sumame)	
Maryland 2121	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "natural", or itams 23a or 28a-1 show eumatic event, it a Madical Examiner must be notified at	ToB	Luigi Cimino				na Maria			
ary	2 should and Men is marke eumatic				g Address (Street		ural Route Numb	er, City	or Town, State, .	Zip Code)
	ges 1 and 2 should it of Health and Mer if item 27 is marke or other treumstic				luthering	Road T		, -	ryland	
ore	Pages 1 nent of Hi ant: If itan		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State	of Dispos e <i>ry, crem</i>	sition (Name of natory or other plac		Date	20c. L	ocation - City or	Town, State
altimore,	. Pag tment tent:				Cemeter					Pennsylvania
Ba	permit. Page Department importent: It any injury o		21. Signature of Funeral Service Licensee Muchael A Rud A		1050 Yor	k Road	Towson,	Mar	uneral yland 2	Home, Inc. 1204
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente						Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	n	conf	estour	henit	417	ease	mont h
	/Medical Examiner		resulting in death) Due to (or as a consequence	e (et):	0	/ -				
	Examine	_	Sequentially list conditions, flags, leading to immediate	ny	Arten	r disk	150			Jeans
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	B 01).	,					V
•	xecut and	xan	that initiated events c	e of):						
8760,	cate be executed physician and the burial-transit	dlcalE								
687	ficate p phys	edlo	0							
Box	leath certifica attending ph	N/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	h a	Ectopic pregnancy	,			23d. Date of de	
œ.	Physicien: The law requires that the death certificate has been signed by the attending praid director, page 2 should be detached for use as	by Physician/Med	in the past 12 months? 4 Pregnant at time of death		Other (specify)				Month	Day Year
P. 0.	at the	hys	9 Unknown				ooo Did	Inhana	use contribute t	o the cause of death?
	signed I		Part II. Other significant conditions contributing to death but not resulting	in the un	nderlying cause giv	en in Paπ I.			4	robably 4 DUnknown
ord	w requir been si should	ted	Dementer				-		/	
Vital Records,	a law nas b e 2 st	Completed	Artic Sterosus				24a. Wa auto	s an opsy formed?		utopsy findings available completion of cause of
E E	: The	Cor		_			1 ☐ Yes	2 X N		2 □ No
ĬĬ.	icien certifi rector	Be	25. Was case referred to medical examiner? Hospital:		• all post Oth	ner .	ath (Check only		2 1001-100	
of	Phys ral di	: To		. Time of	t 3L DOA	4 🗆 Nursing i	Home 5 Res 28d. Describe		6 Other (Speury occurred	Scriy HASPICE
on	ding th. After	tlon		Injury		rk? Yes 2 □ No				
Division of	Atter r dea ector by the	Ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, f	farm, stre	eet, lactory, office		28f. Location City or To			ural Route Number,
á	s afte si Dire	Certification:	4 Homicide determined building, etc. (Specify)				Sity of 11	, Utdi		
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerei Director: After this certificate has completely filled in by the funeral director, page 2	dical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated.	and/or inv	vestigation, in my o	pinion, death occ	urred at the time	, date ar	nd place, and du	e to the cause(s)
	To the Vithin To the Somple	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. D	ate signed (Mon	th, Day, Year)
)	~		If. Hothing Kiley, and		02	-5205		MP	1118	,2005
j	17		30. Name and address of person who completed cause of death (Item 23a)	a) (Type,	Print)	ales J.	7. Ba	eto	md	21208
	Sta Registi	ite ar	29b. Signature and title of certifier 30. Name and address of person who completed pays of death (Item 23a) 31. Date liled (Month, Pay Year) 1 2005 32. Registrar's Signature	A	perti					
			J. Committee of the com							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SOU Xear Month April **Physician** Helen Charlotte Townshend 5:14 \mathbb{P}^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Long View Nursing Home Manchester Carrol1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M XXF Yrs. 215-07-1598 Director 100 June 30,1904 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner aust be notified at 1 ☐ Yes XXNo Director MD Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3240 Main Street Box 95 or items 23a 21102 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White XXWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles Willis Kiler Orlanda Mae Haines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is many injury or other traum once. 3240 Main St. Box 95 Manchester, MD 21102 Dorothy Townshend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MUXBurial 2 Cremation 3 Removal from State 01d Lutheran Cemetery 4/11/05 Manchester, MD 8 Other (Specify) 4 Donation 21. Signature of un ral privice License 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, Maryland 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Onset and Death Immediate Cause (Final **Physician** numonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the hirrial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2. No 3 Probably 4 □Unknown racheal 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 24 No Secter 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ♣No wrsing Home 5 ☐ Residence 6 ☐ Other (Specify) 70 nours after death.

nerel Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

4111 L. Beckleysville

32. Registrar's Signature

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

D.V. taustine. m. D.

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Maryland / Dep		•	2005	12165
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last, Sandra Lee Willoud Aa. Facility Name (If not institution, give 742, Middle, Last, Sandra Lee Willoud	ghby	4b. City, Town, or Location of Death	April 9,	Day Year 2005 4c. County of Death	3. Time of Death
	Funeral Director		742 Middlesex Rd. 5. Social Security Number 216 40 2361 Usual Residence of Decedent	7. Age (In yrs. last birthda]M 2⊠F 62 Yrs.	ESSEX // If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 16, 19	Baltimo 9. Birth Cou 942 Viro	re place (State or Foreign ntry) Jinia
d 21215-0036 filed within 72 hours after death with the Marylend	28a-f show	ector	10a. State 10b. County Maryland Baltimore	10c. City, Town or I	sex			10d. Inside City Limits 1 Yes 28 No
r death with	ema 23a or 3 er nast be n	Funeral Director	742 Middlesex Rd.	12. Was Decedent Ever in U.S. 13	10f. Zip Code 21 221 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puent		USA 14. Race - Ameri Black, White,	can Indian,
2 hours after	naturel", or it		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Edu	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Whi	te.
Maryland 21215-0036	Hygiene. other than "n ent, the Med	e Completed by	(Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+) 1 (Giv	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) Secretary 18. Mother's Nar	king ne (First, Middle, Maid	Hospital	
laryian 2 should be	and Mental is marked or reumatic eve	To Be	John M. Phillips 19a. Informant's Name/Relationship (Ty.		Inez Soling Address (Street and Number or Ru	exton oral Route Number, Cit	ty or Town, State, Zip	Code)
Battimore, No Permit. Pages 1 and	Depertment of Heelth and Mental Hygiene. Important: or Itema 23a or 28a-f show Important: If Item 27 is marked other than "naturel; or Itema 23a or 28a-f show any injury or other treumatic event. It a Medical Examinet must be notified at 2008.		Yvonne M. Shafer (I 20a. Method of Disposition 1 Surial 2 Cremation 3 P 4 Donation 5 Other (Specify)	20b. Place of Disp	Middlesex Rd. Balt position (Name of ematory or other place) Of Faith Cemetery	Date 20c	Location - City or To	
Dait	Depentra Importa any inju		21. Signature of Funeral Service License	Jallian Sr	22. Name and Address of Facility Bruzdzinski Funer 1407 Old Fastern	al Home P.	Δ.	1221
/	ysician Medical xaminer		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	eations the deused the death. Do not enter cause on each line. Due to (or as a consequence of):	tructive Lung Dis			Approximate Interval Between Onset and Death
cate be executed	physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	~1 hy		, ii	
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	certificate has b rector, page 2 sl	e Completed	25. Was case referred to medical		26 Place of Dog	24a. Was an autopsy performed' 1 Yes 2X th (Check only one)	prior to co death?	psy findings available mpletion of cause of 2 No
JII O II O	h. After this funeral dii	ation; To B	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ent 3 DOA Other: 4 Nursing H	ome 5 Residence 28d. Describe how in		y)
DIVISION	within 24 hours efter death To the Funerel Director: completely filted in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify) sician: To the best of my knowledge, dea		28f. Location (Street City or Town, Sta	ate)	
To the Hos	within 24 h To the Fun completely	Medica	(Check only one) 2 Medical Examir 29b. Signature and title of certifier	ner: On the basis of examination and/or i and manner stated.	29c. License number	rred at the time, date a	Date signed (Month,	the cause(s)
	6		30. Name and address of pers in who co	mpleted cause of death (Item 23a) (Type	D 5 3 6 9 4	Beltin	MILLE	21237
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 1 2005	g32. Registrar's Signature	des	THE PARTY OF THE	laigh	2 4143/

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** April 2005 Anna Mae Wares 9:15pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Nursing Home Rockville 1 Year | If Under 24 Hrs Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 □ M 2 🖾 F Hours Min. July 20, Director 1923 Pennsylvania 186-22-6393 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Directo Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24433 Ridge Road 20872 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 <u>Sarah Jordan</u> Horace Patrick Golden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Shuggars/ Daughter 24433 Ridge Road, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 4/9/2005 Silver Spring, Maryland 21. Signature of Funeral Service 01in L. Moleswrth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) detached the 9 ☐Unknown cete has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 ☐ Probably 4 ☑ Unknown Parkinsons Disease 1 ☐ Yes 2 ☐ No Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus Hypertension autopsy performed?" 1 ☐ Yes 2 ☑ No 1 Yes 2 No this certificete funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 No Medical Certification; To 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. investigation 2 Accident the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 D28656 6, 2005 April ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ac Ravi Passi, MD 15225 Shady Grove Road # 208, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) APR 1 1 2005

DHMH 17 Rev 1/2001

State Registrar

32. Pojistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For Stata Registrar	State of Ma		rtificate of De			gierie Reg. No.	
	Physici		Decedent's Name (First, Middle, La Aloysius	E.	Wagner			2. Date of De Month April .	7, 2005	3. Time of Death 4:40 PM
	/Medic Examin		4a. Facility Name (If not institution, giv Genesis Eldercare		Contor	4b. City, Town, or Lo	ocation of Death		4c. County of Dea	
* ·	Funeral Director		5. Social Security Number 6. S		(In yrs. last birthday) 81 Yrs.	If Under 1 Year I	f Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da June 26	th 9. Bi	nthplace (State or Foreign ountry) aryland
	Maryland f show	or	Usual Residence of Decedent	ore	10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2X No
	h with the 1 3s or 28s-	Funeral Director	10e. Street and Number 8019 Park Haven R	oad		10f. Zip Code 21222			10g. Citizen of What C	country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23s or 28s-1 show any injury or other treumatic event. It is Medical Examera front be notified at 905s.	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 □ N If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes ♣️♣️No	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	0/4	
Maryland 21215-0036	ithin 72 hou ie. ien "natural	Completed I	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation	(Give	dent's Usual Occupation of kind of work done dur DO NOT use retired)	on ing most of work	ing	16b. Kind of Business	·
d 21	filed with Hygiene other the	Be Con	12 years 17. Father's Name (First, Middle, Last)	Cabi	net Maker	B. Mother's Name	e (First, Middle,	Carpentry Maiden Sumame)	7
ylan	Mental Merked o	ToB	George H. Wagner					ergemi.		
Mar	and 2 should salth and Men n 27 Is marke er treumatic		19a. Informant's Name/Relationship (Dorothy Wagner	Type, Print) wife					er, City or Town, State, k,Md。 21222	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tre anges.		20a. Method of Disposition 1 XBurial 2 Cremation 3 C 4 Donation 5 Other (Special	Removal from State		osition (Name of matory or other place) 11 Memoria		21° 11, 05	20c. Location - City o	
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Lice	Sh					Dundalk,P.A Dundalk,Md.	
1	Physician		23a. ra.1. Enter the disease, or com- mock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	the death. Do not en	ter the mode of dying,	such as cardiac o	DISE	ASE	Approximate Interval Between Onset and Death
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.O. Box (The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	elivery Day Year
<u>α</u>	quires that I n signed by uld be deta	ed by Ph	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	underlying cause given	in Part I.		obacco use contribute Yes 2 ☐ No 3 ☐ F	to the cause of death? Probably 4 Unknown
Records,	The law require ate has been si page 2 should b	Completed								
Vital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 Vo	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	Other	6. Place of Death		one) dence 6 Other (Sp	ecitu)
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)	To the within 2 To the complet	M	29b. Signature and title of certifier	14 Tax	Va MS	29c. License r	1918	3	29d. Date signed (Mor	nth, Day, Year)
١	2		30 Name and address of person who	completed cause of d	eath (Item 23a) (Type	, Print)	Place		untille!	402122
Ė	Sta Registi		31. Date filed (Month, Day, Year)	32 Registra	r's Signature	artie			10/4	

				State of Marylar					•	
			1 - For State Registrar	, , , , , , , , , , , , , , , , , , , ,		tificate of			2005	12168
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	Examir	ner	4a. Facility Name (If not institution, give				Location of Death	•	4c. County of Dea	uth
			JOHNS HOPKINS 7 5. Social Security Number 6. Sec			BALTI If Under 1 Year	If Under 24 Hrs.	9. Date of Righ	0.00	
L	Funeral Director			M 200 € 7. Age (in y/s.	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. BI	rthplace (State or Foreign ountry)
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	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f ahow ont, Ite Medical Executive meative multified an	20	1 1 10 1		Esse					10d. Inside City Limits 1 ☐ Yes 2 ☐ Ho
	28a-	Funeral Director	10e. Street and Number	MORE 1	-326	10f. Zip Code		100	g. Citizen of What C	ountry?
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	Items (ner	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Whi	erican Indian,
36	or It	by Fu	1 Never Married 2 Married	1 ☑Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	ritioari, otc.,	Specify:	1 /
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Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic	1	19a. Informant's Name/Relationship (7		19b. Mailir	g Address (Street	and Number or Rur	al Route Number, (City or Town, State.	Zip Code)
	Heali Heali tem 2	1	EGON WINTER 20a. Method of Disposition	(Husham)	Place of Dispo	sition (Name of natory or other place	NE /G)	HOLE M	Town, State
ē	ages ant of nt: If Ii		1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify		cemetery, cren	Coo d	Apri	111,2005 R	Human	Man I 1
Baltimore,	permit. Pages Department of I Important: If ite any injury or of once.		21. Signature of Funeral Service Licen		TYMEN 23	CREMATORY.	ss of Facility	0/15	oc. Location - City of AHIMORE Al Homes A	10ARY LAND
m	Depa Depa Impo any ir	J. J.	Mark (Lomack	- 10	OS Dunda	16 Ave. B	altimore.	MARYLAND.	21224
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	it the de by the a tached f	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of o 9□Unknown	ieath 5	Other (specify)			Monar	zuy rour
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Division of Vital Records,	ding f	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	yat k? Yes 2 □ No	28d. Describe how	injury occurred	
isi	Attended death ctor:	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	ome, farm, stre		165 2 110	28f. Location (Stre	et and Number or R	ural Route Number.
Ö	i gi te	Certification:	4 Homicide determined	building, etc. '(Specif	(y)			City or Town,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	owledge, death	occurred at the tin	ne, date and place,	and due to the cau	se(s) and manner a	s stated.
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3	,		30. Name and address of person who comp. DR. DAVID LIM, 4	1940 EASTERI	N AVE	JUE BA	LTIMORE	MD	21224	y.
	Sta	te	31. Date filed (Month, Day, Year) APR 1 1	32. Registrar's Signa	ature &	South .		·		
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			For State Registrar		f Marylar		artmen tificate			and M	1	Reg. No.	2005	121	69
	Physici	an	Docedent's Name (First, Middle, DORIS MAY WEI	*	2						2. Date of De Month APRIL	Day	Year	3. Time of D	Death
	/Medic Examin		4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	of Death	APRIL	7	2005 County of Death	2340	
	LAGITHI	CI.	GLEN MEADOWS				GLI	EN A	RM			В	ALTIMOR	Œ	
	Funeral Director		215-16-6307	3. Sex 1 □ M 2 □ x F	7. Age (<i>In yr</i> s. 8 1	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 5/21/19	y, Year) 23	9. Birth Cou MARY	place (State or Intry) LAND	Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City	Limits
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinant must be neithed at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	Armed Fo	2 ∑X No e	İ	was Deced fYes, spec I∐Yes 2		spanic Ori n, Mexicar Specify:	gin? (Sp i, Puerto	ecify Yes or No Rican, etc.)		4. Race - Ameri Black, White Specify:		
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Maryland	2 shou and N Is mai		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address	(Street a				er, City or	Town, State, Zi	p Code)	
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	Physician /Medical Examiner 23 1 In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limited and disease or condition resulting in death) 23 1 In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limited and disease or condition resulting in death) 24 2													Approximate Interval Betwee Onset and De	ath
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ì	Toth within Toth comp	Me	29b. Signature and title of certifier	Bamman	A GOP	ALKN	mo	D	number	28	+	4	signed (Month,	Day, Year)	
7			30, Name and address of person w PAMAN HO 31. Date filed (Month, Day, Year)	o completed cause	e of death (Ite) ^{23а} /луре,	PROL	LIV	146	12 05	s Ropa	s #1	BALTIM	one 21	228
	Sta Registr		31. Date filed (Month, Day, Year)	1 1 2005	egistrat Signa	ature	500	de	i						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For the Registrar amend item 35 per fh 8842 4 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death April 5, 2005 **Physician** 5:00 p Arlene Emma Weegar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2310 Harcroft Road Baltimore Timonium If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Spoial Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March B, 1928 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Director Yrs. Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be nutified at Completed by Funeral Director Maryland Baltimore Timonium 1 Yes 2 No 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1. Department of Health and Mental Hygiene. The professit if item 27 is marked other than "netural", or items 23a or 21 any Injury or other fraumatic event, the Medical Exeminar modes. 10f. Zio Code 10g. Citizen of What Country? 2310 Harcroft Road 21093 LISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Cun Hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Daniel Mattern Elizabeth **Hamilton** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklyn Charles Weegar/Husband 2310 Harcroft Road Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/9/05 Dulaney Valley Cem. * 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1050 York Road Ruck Touson Funeral Hone, Inc. Touson, Md. 21204 a au 23a. Part1. Enter the disease, or complications that used the shock, or heart failure. List only one caus are each line used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) uens three days /Medical Due to (or as a consequence of Examiner Sequentially list conditions, any leading to minimum accause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events the attending physician and resulting in death) Last FAX 70 m. C. IOK/XC Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 🗹 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1∐ Yes 2 No 1 ☐ Yes 2 ☐ No. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No Certification: To 5 Residence 6 □Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number D 2 6 6 3 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2005 32. Registrar's Signature Gris wold Osler Dr. #303. 7505

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear Physician 0908 0 03 DAND ARWOND WILHEUM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** (CARROLL HOSPITAL CENTER Cashon WESTMINGTER If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number 6 Sex **Funeral** 1 M 2 □ F Months 216-30-6938 Μď 04-19-33 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 23a or 28a-1 show any injury or other traumatic event, the Machell Examinar many once. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. Count Md Carrol1 Westminster 1 ☐ Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 USA 994 Hacienda Court 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry home improvement Elementary/Secondary (0-12) College (1-4or 5+) painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Taylor Harry Wilhelm ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 994 Hacienda Ct., Westminster, Md 21157 Edna Louise Wilhelm (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, Md Wesley Freedom Cem. 4-8-05 ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Parge Harget terestrage P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ue to (or as a consequence (f): disease or condition resulting in death) /Medical **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit M Due to (or as a con equence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown ğ 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 3 ☐ Probably 4 ☐ Unknown 2 No 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 2 2 No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes this 27. Manner of Deal 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a Medical Examiner: On the best of my knowledge Medical Examiner: On the basis of examination and manner stated. courred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the Vithin 2 29d. Date signed (Month, Day, Year) certifier 29c. License number 29b. Signature and title q

State Registrar o death (Item 194) (Type, Print)

32. Registrar's

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			1 - For State Registrar	State of M	laryland / D	•	irtment of H tificate of L		а ме	_	giene Reg. No.	200	5 2	72
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	Director		220-38-2167 Usual Residence of Decedent		02				M	ay 14,	194	Z We	ashington	
	Manylan I-f ehow	tor	10a. State 10b. County Maryland Calver	rt	10c. City, Town	or Loc ve 1							10d. Inside City 1 ☐ Yes	
	or 28a	Direc	10e. Street and Number				10f. Zip Code					zen of What		
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f ehow any injury or other traumatic event, the Madical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4XXX Divorced	12. Was Decedent Armed Forces d 1 Tyes 2 M If Yes, Give Year or Dates:	?		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2【 No	spanic Origin n, Mexican, P Specify:	r (Speci vuerto Ri	an, etc.)			White, etc.	
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DHMH 17 Rev 1/2001

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	Maryland -Pahaw		10s. Siete 10b County		10c. City, To	own or Loc	ation						10d. Inside City Limit
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	To the wilkin ? To the complete	Ned	230. Signature and life of certifier	êfiti manner stated.	•		29c. Licanse						
	8 - 3 -				MO		ESC. EGENSO	NGTH DMT		290. 0	ate signeo (A	viantin, Qa	y, Yeur)
_		-	TO Name and address person who to	ormania de la composición dela composición de la composición de la composición de la composición dela composición de la composición de la composición dela composición dela composición de la composición de la composición de la composición dela composición	/line ===	(D)(F= 5	D35635			Mar	ch 5,2	2005	
00	over	1	Joseph Kaplan M.D	6001 Munc			*	barilla	MD 00	000			
,	. Stat	e l	31 Date Hed (Month Day, Year)	32. A gistrar's	Signature			kville,	MD 20	לכטו			
	Registra	1	MAR 0 7 2	005 Kare	· Lite	Post .	200						
DHN	H 17 Rev 1/200	31	•			7			-				

		•	For State Registrar		State of I	Marylan		artmen			and M	lental Hy	giene Reg. No:	005	12	174
			1. Decedent's Name (First, Mic	ldle, Last	")							2. Date of De	eath Day	Year	3. Tim	ne of Death
	Physici /Medic		ANTHONY HEN	RY B	ANKS							MARCH	22,	2005		:20P M
)	Examin		4a. Facility Name (If not institut	ion, give	street and numb	er)		4b. City,	Town, or	Location of	of Death			unty of Death		
			PRINCE GEOR					If Under		EVERL If Under		O Data of Bi		RINCE		
	Funeral		5. Social Security Number	6. Se	X /. X M 2 ☐ F	•	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da	ay, Year)			ate or Foreign
	Director		577 72 2015 Usual Residence of Decedent			50			-			MAR. 28	5, 195	4 WAS	HING.	TON, DC
	death with the Maryland ims 23e or 28e-f show if must be notified at		10a. State 10b. Cour	ity		10c. Cit	y, Town or Lo	cation								de City Limits
	Mar e-f st	tor	MARYLAND PRIN	CE G	EORGES	SEA	AT PLEA	ASANT							XX.	Yes 2 □ No
	or 28	Director	10e. Street and Number					10f. Zip	Code				10g. Citizer	of What Co	untry?	
	23e		711 CARRINGTO	N PL						2074				TED ST		
	er de	Funeral	11. Marital Status		12. Was Decede	es?	.S. 13.	Was Deced If Yes, spec	lent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spo 1, Puerto	ecify Yes or No Rican, etc.)	0- 14.	Race - Ame Black, White		.n,
3	hours after tural', or Ita	by F	XIX Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divord	1	1 ☐ Yes X If Yes, Give Year or Date			1 ☐ Yes	X No	Specify:			Sp	ecify: BL	ACK	
9500-61212	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "netural", or Itams 23e or 28e-1 show avant, the Medical Exantret matter cutting at	led	15. Deced		ucation		16a. Dece	dent's Usua	d Occupa	ation		·	16b. Kind	of Business/l	ndustry	
2 2	within 72 ene. than "nei	Completed	(Specify only hig Elementary/Secondary (0-12		de completed) College (1-4	or 5+)	(Give	kind of wor DO NOT us	nk done d se retired	furing mos)	t of work	ing				
7	giene giene gritha	Com	Listinonia, 7. Secondary (6.7.	<u></u>	1 YR			DISA	ABLE							
2	be filed tal Hygie d other avant, t	Be (17. Father's Name (First, Midd	e, Last)						18. Mothe	er's Name	e (First, Middle	, Maiden Su	mame)		
yland		ို	HENRY BANKS									JOHNS				
Mar	d 2 should th and Mer ?7 Is marke traumatic		19a. Informant's Name/Relation		ype, Print)			_				al Route Numb				_
	s 1 and if Health itam 27 other to		SHIRLEY BANKS 20a. Method of Disposition	/ M	OTHER	20h F	711 (Place of Dispo	CARRII		N PL.		SEAT PI		T, MD		
<u> </u>	Pages I nent of H int: If its iry or ot		XX Burial 2 Crematic			ate	emetery, crei	natory or o	ther plac	1				•		
Baltimore,	nit. Paramen ortent: injury		* 4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Servi			GLI	ENWOOD					9/2005		HINGTO		<u> </u>
g	permit. Pages Department of I Importent: If it any injury or o		P. M.	aus .	Lll			ARSHAI 308_SI				HOME OF	F MARY	LAND,I MD 207	NC. 46	
	è		23a. Part1 Enter the disease shock or heart failure.	or comp	lications that cau	sed the deat h line.						or respiratory a	arrest,		Approx Interva	I Between
	Physician		Immediate Cause (Final disease or condition		a PNEUM										Onset	and Death
	/Medical		resulting in death)		α	as a conseq	juence of):									
	Examiner		Sequentially list conditions,		b											
	ad sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ł	Due to (or	as a conseq	juence or):									
	and and Il-tran	хап	that initiated events resulting in death) Last		c Due to (or	as a conseq	juence of):									
09/	te be executed ysician and he burial-transit	calE			J											
/89	# % B			•	d											
ROX	death certificat e attending phy ed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outco			DEctopic pr					23d	. Date of deli	,	
	death e atte	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No		4□Pregnar	h 2 □ Feta at at time of d		Other (sp						Month	Day	Year
J.	at the de by the a	hys	9 Unknown		9□ Unknow	n										
	law requires that the as been signed by th 2 should be detache	by F	Part II. Other significant cond			th but not res	sulting in the u	nderlying c	ause give	en in Part I			tobacco use			
or d	w requir been si should	ted	HEPATITIS, A	NEM1	A							10	Yes 2 1		boably :	XXUnknown
Records,	law I las be	Completed										24a. Was	psy	4b. Were au prior to death?	topsy find completion	ings available of cause of
<u> </u>	The law	Con										1 ☐ Yes	ormed?		2 🗆 No	
Vital	Physiclan: Th this certificate ral director, paç	Be	25. Was case referred to med examiner?	-	Hospital:				Othe			h (Check only				
0	Phys this al dii	To :	XX Yes 2 □ No 27. Manner of Death		. 1 🗆 Inb		ER/Outpatie					ome 5 Res			cify)	
S	ling After fune	tlon	XXNatural 5 ☐ Per	ding stigation	28a. Date of (Month,	Day Year)	Injury	М	8c. Injury Work 1 □ '	k? Yes 2 □			,.,			
DIVISION	r Attanding er death. ractor: After by the fune	fica	3 ☐ Suicide 6 ☐ Cou	id not be	28e. Place of	f Injury - At h	ome, farm, st	reet, factory	, office			28f. Location		lumber or Ru	ral Route	Number,
2	i Pite o	Certification:	4 Homicide	,,,,,,,,,	building	, etc. (Specil	(y)					City or 1 o	wn, State)			
	To the Hospital or Attand within 24 hours after death To the Funaral Diractor: completely filled in by the		29a. Certifier XX Certification (Check only 2 Media	ying Phy	ysician: To the b	est of my kno	owledge, deat	h occurred vestigation	at the tin	ne, date ar pinion, dea	nd place, ith occuri	and due to the red at the time,	cause(s) an	d manner as	stated.	1 se (s)
	To the h within 24 To the F complete	Medical	one)	41	and manne	r stated.		200	License	e number			29d Date s	igned (Montl	Day Ye	arl
	To To Con	-	29b. Signature and title of cert		001	/	. ^	290						-		
	70		Alberi	12	vell	-, M	٠ لعد،	Date in	D79	0/			MARC	Н 23,	2005	
/	(3)		30. Name and address of pers			of death (Iter	n 23a) (Type, 600 R		EMD.	R∩∆⊓	EC.	RT WAS	HTNGTO	N. MT	2074	4
	Sta	te.	ALBERT E. RO	ar)	3 Rec	istrar's Signa	ature		עוונה	NORD		AL WAD		,		-
	Registi		MAR 2 8	200	5 Kee	n d	for	Le								

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma		artment of Health a rtificate of Death		giene 05	12175
	Physici		Decedent's Name (First, Middle, L Carroll		vin	Posses	2. Date of D Month	eath Day Yea	
	/Medi Examir		4a. Facility Name (If not institution, gi		V 111	Boggs 4b. City, Town, or Location of	MARCH of Death	26 2005 4c. County of De	
-	Funeral		- 1	Sex 7. Age	e (In yrs. last birthday)	CUMBERLAND If Under 1 Year If Under Months Days Hours		ALLEGAN rth av. Year) 9. 8	IY irthplace (State or Foreign Country)
	Director		220-10-7541 Usual Residence of Decedent	1 M 2 □ F	86 Yrs.		04/25/2		t Virginia
	yland Jow		10a. State 10b. County		10c. City, Town or Lo	cation			10d. Inside City Limits
	a-fsh	ctor	MD Alle	egany	Cum	berland			1 □ Yes 2 No
	ith the)ire	10e. Street and Number			10f. Zip Code		10g. Citizen of What 0	Country?
	ath w	rai	12507 Lisa D			21502		USA	
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or Iteme 23a or 28a-f show event, the Medical Evantina must be resulted at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent If Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	lo	Was Decedent of Hispanic Ori f Yes, specify Cuban, Mexicar 1 ☐ Yes 2 ☒ No Specify:		14. Race - An Black, Wh Specify:	ite, etc.
2-00	2 hou	ted	15. Decedent's 8	ducation	16a, Dece	dent's Usual Occupation		16b. Kind of Busines	White s/Industry
21215-0036	filed within 7 Hyglene. other then "n ent, the Med	Completed by	(Specify only highest girls) Elementary/Secondary (0-12) 12	College (1-4or 5	+)	kind of work done during mos. DO NOT use retired) Professional	t of working	Sports	,
pu	al Hygie d other	BeC	17. Father's Name (First, Middle, Las			18. Mothe	er's Name (First, Middle	, Maiden Surname)	
yla		To I	Loyal	Washington				Catherine	
, Maryland	5 를 2 급		19a. Informant's Name/Relationship Larry Boggs /		100	ig Address (Street and Number ${ m Eleanor}$ Stree			Zip Code) 21502
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 △Burial 2 □ Cremation 3 [Removal from State	20b. Place of Dispo cemetery, cren	natory or other place)	Date	20c. Location - City o	
Itim	rtmen rtant: njury		' 4 □ Donation 5 □ Other (Speci	• •	Sunset M		03/30/2005		•
Ba	permit. Pages. Department of It Important: If ite any injury or of		21. Signature of Furieral Service Lice	-adom		. Name and Address of Facilit 404 Decatur	Street, Cu	mberland,	Alta III. Sales
Е			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not ente	er the mode of dying, such as	cardiac or respiratory a	rrest,	Approximate Interval Between
	Pnysician /Medical	7	Immediate Cause (Final disease or condition resulting in death)	a. Corone		y Disease			Onset and Death
Н	Examiner			Due to (or as a	a consequence of):	8			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a consequence of):				
	cate be executed physicien and the burial-transit	Examiner	that initiated events	С.					
60,	be excien a		resulting in death) Last	Due to (or as a	a consequence of):				
68760,	tificate of physical as the t	edicai	L==	d					
Вох	death cer e attendir id for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of de Month	Nivery Day Year
0	d by the	Phy	9 Unknown		A = A = = Mi =			1	
	w requires that the been signed by the should be detache	ted by	Part II Other significant conditions		t not resulting in the ur	derlying cause given in Part I.		obacco use contribute t Yes 2'∰No 3 ☐ P	o the cause of death?
	The law ate has b page 2 s	Completed by					24a. Was autor perfo 1 \(\text{Yes} \)	rmed? prior to death?	utopsy findings available completion of cause of
Vita	Physiclen: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Noia-t-			of Death (Check only o		
of	Phys this al dii	on; To	1 ☐ Yes 2 📆 No 27. Manner of Death 1 📆 Natural 5 ☐ Pending	Hospital: 1 La Inpatier 28a. Date of Injury (Month, Day)	nt 2 ☐ ER/Outpatient / 28b. Time of Injury	3☐ DOA Other: 4☐ Nur 28c. Injury at Work?		dence 6 Other (Spenow injury occurred	cify)
Sio	Attending r death. ector: After by the fune	catic	2 Accident investigatio	n		M 1 Yes 2 N	10		
Division	i Pite	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm, stre . <i>(Specify)</i>	et, factory, office	28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
	Hospitel 24 hours a Funeral tely filled		29a. Certifier 1 K Certifying Ph	vsician: To the best o	f my knowledge, death	occurred at the time, date and	I place, and due to the	Cauca(s) and menas a	- total
	ne Ho n 24 h ne Fui	Medical	(Check only 2 Medical Exam	niner: On the basis of and manner stat	examination and/or inv	estigation, in my opinion, death	h occurred at the time,	date and place, and due	e to the cause(s)
	To the within 2 To the complet	Ĭ	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mont	
12	I, UA			ytur		Doo33	280	March 2	8,2005
. /			30. Name and address of person who	completed cause of de	ath (Item 23a) (Type, F	Print)		4 4	
	nred Star	0	31. Date filed (Month, Day, Year)	32. Regulara	r's Signature	e. Cumber	land, Mar	yland 2	502
	Registra		MAR 28	2005	r's Signature				

			1 - For State Registrar	Sta		-		f Health	and Mental H		9.05	12176
	Q	÷	1. Dacedent's Name (Firs	t, Middle, Last)					2. Date of D	eath	<u> </u>	3. Time of Death
	Physic /Medi		Lydia	Mitchell	Barch	ners			Month Marc	Day h 24,	Year 2005	4:37P M
	Exami		4a. Facility Name (If not in				4b. City, Town	n, or Location			inty of Death	4:3/P
			Frederi	ck Memor	ial Ho	spital	Fred	erick		Fre	deric	k
	Funeral		5. Social Security Number			(In yrs. last birthday) If Under 1 Ye Months Da		24 Hrs. 8. Date of B Min. (Month, D	irth	9. Birthpl	ace (State or Foreign
	Director		577-20-3290	1 M 2	MF	83 Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	April :	21, 192	1 Wash	ington,D.C.
	and w		Usual Residence of Dece 10a. State 10b.	County		10c. City, Town or t	ocation					Od. Inside City Limits
	Mary f sho	ō	Maryland F	rederick		Frederick					"	1 Pres 2 □ No
	28a	lec.	10e. Street and Number				10f. Zip Cod	9		10a. Citizen	of What Count	trv?
	3a or	0	607 Biggs Av	enue			21702			U.S.A		.,,.
	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-1 show ha Medical Examinar must be notified at	Funeral Director	11. Marital Status	12. Wa	s Decedent E	ver in U.S. 13	Was Decedent	of Hispanic Or	igin? (Specify Yes or N n, Puerto Rican, etc.)		Race · America	
9	after or Ite	Ē	1 Never Married 2	Married 1	ned Forces? Yes 2 ☑ No	6					Black, White, e	
21215-0036	irel',	d by	3 ☐ Widowed 4 ☐ D	ivorced Yea	es, Give ar or Dates:		1 ☐ Yes 2 ☑ 1	No <i>Specify</i> :	:	Spe	cify: whit e	=
5	72 h	Completed	15. D (Specify only	ecedent's Education y highest grade comp	oleted)	16a. Dec	edent's Usual Oc e kind of work do DO NOT use ret	cupation ne during mos	st of working	16b. Kind o	Business/Ind	ustry
12	Mithir Shen Shen Shen	m du	Elementary/Secondary	(0-12) Col	llege (1-4or 5+	.)		tired)				
2	filed will Hygien other th		17. Father's Name (First,	Middle Last)		Secre	tary	19 Mothy	er's Name (First, Middle			Energy
ano	ould be a Mental I arked o	Be C	Alton Farr						11a Lyons	a, maiden Sun	ате)	
Maryland	2 should and Men is marke eumatic	To	19a. Informant's Name/Re		nt)	10h Mai	ing Address /Stre		er or Rural Route Numb	or City or To	Ctata 7in	Codel
Z	ith and 2 s		Earl Barche						Frederick,			
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. item 27 is marked other then "naturel", or Items 23a or 28a-1 show other treumatic event, The Medical Examinar must be notified at		20a. Method of Disposition	r		20b. Place of Disp cemetery, cre			Date		n · City or Tov	
Baltimore,	ant cannot be sent ca		1 ☐ Burial 2 ☐ Cren 4 ☐ Donation 5 ☐ C	mation 3 Remova	I from State			1	/20/2005	P 1	. 1	
Ħ	그 든 만 글		21. Signature of Funeral S		1	Frederic	2. Name and Ad		/28/2005 V Stauff	Freder er Fun	lck, Ma erel Ho	iryland
m	permi Depa Impo any ir once.		Tharow)	Carrilla	Pin				n Pike, Fre			
		_	23a. Part1. Enter the dise shock, or heart failur	ease, or complications	that caused t							Approximate
	Priysician		Immediate Causa (Final disease or condition	A. List Offiy Offe Caus	R. R.	EC DIGHTS	V FAU (er-Dur	To Sleep 1	ADME A		Interval Between Onset and Death
	/Medical		resulting in death)	a. NC	ue to (or as a	consequence of):	-[nicoi	NG 746	10 scel	They		
	Examiner		Sequentially list condition	_b C	ORON	nry m	LTERY	DISEM	+5E			
	D #5	iner	Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	te D	•	consequence of):						
	and and trans	Examiner	that initiated events resulting in death) Last	c		ETIES					- 10	
60,	ate be executed hysician and the burial-transit	calE				E RENA	. En	ILURE	-			
68760,				d	11001	E HENN	- 1	LONE				
	death certificat attending phy d for use as th	Physician/Med	IF FEMALE:	23c. If ye	es, outcome of	pregnancy				004.1	Data of data	
Вох	leath atter	ciar	23b. Was decedent pregn in the past 12 month:	1		Fetal death 3	⊒Ectopic pregnar ⊒ Other (specify)			1	Date of deliver Month E	y Day Year
0		isku	1 □ Yes 2 ☑No 9 □ Unknown		Unknown		_ curor (apcany)					
S,	faw requires that the as been signed by th 2 should be detache	by Pł	Part II. Other significant of	onditions contributin	g to death but	not resulting in the t	Inderlying cause	given in Part I.	. 23e. Did	tobacco use co	ontribute to the	cause of death?
<u>r</u>	quire n sig uld b								10	Yes 2□No	3 🗌 Probai	bly 4 Dunknown
Record	law requir as been s 2 should	Completed							24a. Was	an 24t	o. Were autops	sy findings available
α	e T e	mo								psy ormed?	prior to com death?	pletion of cause of
	i icien : Th certificate rector, pag	a	25. Was case referred to r	nedical				26 Place	1 ☐ Yes of Death Check only	2 (No	1 ☐ Yes 2	2 L No
>	di S	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital	1 Inpatient	2 ☐ ER/Outpatie	nt 3 DOA		rsing Home 5 ☐ Resi		ther (Specify)	
	ng Ph ter th neral		27. Manner of Death	28a.	Date of Injury (Month, Day		f 28c. In	jury at	28d. Describe			
<u>.</u>	Attending It death. ector: After by the fune	atlo	2 Accident	investigation	(injury		□Yes 2□!	No			
Division	l or Att	Certification:	3 Suicide 6 4 Homicide	Could not be determined 28e.	Place of Injury	 At home, farm, st (Specify) 	reet, factory, offic	:0	28f. Location (City or To		nber or Rural i	Route Number,
	itel o irs aft ral D led ir			/								
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	Check only 2 M	adical Examiner: On	the basis of e	xamination and/or ir	h occurred at the vestigation, in my	time, date and	d place, and due to the the time,	cause(s) and date and place	manner as stat	ted. he cause(s)
	thin 2 the the	Med	one) 29b. Signature and title of		d manner state	od.		nse number				
	To To		lia lia	10 —			_	04795	- 1	29d. Date sign		-
,	: 0	1	30 Name and address of p	norman who completes	d cause of de-	th (Itam 22a) Cr.					2.50	
	<u></u>		. 1		2 0 1 1	an (Item ZSa) (Type,	rint)	t	Property 1	Mo	21-	A
			DIRIEN	TALMI	KIU	LOCK +	HOUSE- F	tue"	INChENICI	·	2110	
	Sta	te	31. Date filed (Mon Mar	TAZMI, 45	32. Egistrar	s Signaturę	house- F	tue "	REDERICH	\ '\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	2110	ol.

Amended Items 18,19a,19b per F.D. 03/25/2005 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	ertificate of L		lental Hygier Reg. I	4000	12177
			1. Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
	Physic /Medi		Charles Jose	ph Bezold				Month 1	Day Year	543 PM
	Exami		4a. Facility Name (If not institution,	rive street and numb	er)	4b. City, Town, or	Location of Death		4c. County of Deat	th
			Carroll Hospi	tal Center		Westm	inster		Carro	11
	Funeral			. Sex 7.	Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea		hplace (State or Foreign
	Director		218-14-0416	1 □ M 2 □ F	94 Yrs.	Months Days	Hours Min.	April 19	1910	mintry)
	P .		Usual Residence of Decedent					140111 19	1910	
	nylar ihow	_	10a. State 10b. County		10c. City, Town or I					10d. Inside City Limits
	B Ma	cto	MD Carr	011	Westm	inster				1 ☐ Yes 2 ☑ No
	ith the Marylar or 28a-f show	Director	10e. Street and Number			10f. Zip Code		10g. (Citizen of What Co	ountry?
	1h wi		214 Bezold Av	enue		21	157		USA	
	dea	ner	11. Marital Status	12. Was Decede		. Was Decedent of His	spanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
9	after death w or itema 23a infost must t	by Funeral	1 Never Married 2 Married	1		If Yes, specify Cubar		Hican, etc.)	Black, White	
03	ral',		3 Widowed 4 Divorced	If Yes, Give Year or Date	s:	1 ☐ Yes 2 ☐ No	Specify:		Specify: Wh	ite
215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. od other than "natural", or items 23s or 28s-f show event, the Medical Evanting must be routified at	Completed	15. Decedent's (Specify only highest		16a. Dec	edent's Usual Occupa	ition	16b.	Kind of Business/	Industry
2	thin 89.	ppl	Elementary/Secondary (0-12)	College (1-4	or 5+)	e kind of work done d DO NOT use retired))	ng		
21	e filed within al Hygiene. I othar then " vent, the Me	5	8		P	lasterer			Self Emp	loyed
p	al Hy al Hy oth vent	Be (17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, Maid	en Sumame)	
<u> a</u>	should be and Mental Ind Mental Insuranted o	2	Henry John Be	zold			Agnes Ka	hler A	gnes Kael	hler
Maryland	S D E E		Margaret No Chres the	Seynour/Da	ughter 196204	ng Bezol zkeA				1 _p 5 c 7 _{de)}
_	₽ £ \$ ₹		Blanche Bezold/	wife	214	Bezold A	venue Wo	stminster	, MD 21	157
Baltimore,	ges 1 ar t of Hea lf itam or other		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other place		ate 20c.	Location - City or	Town, State
E	Pages nent of I int: If its		1 Burial 2 Cremation 3 → 4 Donation 5 Other (Spe		ite .	n Cemetery	1	2005 Ma	stminste:	r MD
星	구두다른		21. Signature of Funeral Service Lic	**						L, PID
B	Deporting Important		1 Me			2. Name and Address Pritts Fund			el, P.A.	21157
	_		23a. Part1. Enter the disease, or co	mplications that cause	sed the death. Do not en	112 Washin	gton Road	Westmin	ster, MD	Approximate
ш			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	ine.	nor the mode of dying	, such as cardiac o	i respiratory arrest,		Interval Between Onset and Death
	Prrysician /Medical		disease or condition resulting in death)	_ a	MARACE	CEBRAL.	Hemo	ARHAGE		GDAYS
	Examiner		1	Due to (or	as a consequence of):				1	,
		_	Sequentially list conditions,	b	SENTIAL	HYPE	RTENSI	٥٨		YEARS
	ed isit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for	as a consequence of).					,
	and and I-trar	Examin	that initiated events resulting in death) Last	C. Due to /or	as a consequence of):					
60,	oe e) cian ouria	Ē		Dub (0 (0)	as a consequence or).					
68760,	icate be executed physician and s the burial-transit	edicai		d						
		Me	IF FEMALE:							-
Вох	eath certifi attending for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth		☐Ectopic pregnancy			23d. Date of deli	*
	e des	Sici	1 ☐ Yes 2 ☐ No	4□Pregnant 9□Unknown		Other (specify)			Month	Day Year
P.0	that the de ted by the a detached t	Physician/M	9 🗆 Unknown	_						
	law requires that the death certi as been signed by the attending .2 should be detached for use a	by	Part II. Other significant conditions	contributing to death	but not resulting in the t	inderlying cause give	n in Part I.	23e. Did tobacco	use contribute to	the cause of death?
rd	v requir been si should							1 🗆 Yes	2 No 3 □ Pro	bably 4 Unknown
S	aw requisibeen	ompleted						24a. Was an	24b. Were aut	opsy findings available
æ	9 4 9	E O						autopsy performed?	death?	ompletion of cause of
ta	ician: Th certificate rector, pag	e C	25. Was case referred to medical				OC Plans of Dooth	1□ Yes 2XN	lo 1 L Yes	2 No
of Vital Records,		0 B	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	ttient 2 ☐ ER/Outpatie	Other	26. Place of Death		0 Flour 10	
	Phys ir this sral di	Ė	27. Manner of ath	28a. Date of It				ne 5 Residence 8d. Describe how inj		ify)
O	ding h. h. After funer	tior	1 SNatural 5 ☐ Pending 2 ☐ Accident investigati		Day Year) Injury	Work	es 2 □No		any cocanoc	
Division	of or Attanding after death. I Diractor: After d in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not	be 390 Place of	Injury - At home, farm, st			8f. Location (Street a	and Number or Pu	m I Pouto Number
S	after Dira	erti	4 Homicide determine	building,	etc. (Specify)	root, tadiory, office		City or Town, Sta.		arribate reamber,
_	e Hospital 24 hours a e Funeral D etely filled i	ŏ	29a. Certifier 1 Certifying I	hyeician: To the ba	et of my knowledge de-	h conversed at the city	, data and at		->	
	Fun Fun Hely	edical	(Check only one)	miner: On the basis aminer and manner	st of my knowledge, deat of examination and/or in	in occurred at the time ivestigation, in my opi	nion, death occurre	nd due to the cause(d at the time, date ar	s) and manner as and due	stated. to the cause(s)
	To the Hospital or Attanding within 24 hours after death. To the Funeral Diractor: After completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral completely filled in the funeral	Mec	29b. Signature and title of certifier	and manner	Statou.	29c. License			ate signed (Month	
	F 3 F 8	-	1	0/	0 40					
1	154		ment	18 -00	Took Noite	1 12	E. MAII		3/24/6	5
1	Ö		30. Name and address of person wh			Print) 477	E. MAII	v 57		
	THE STREET		VINCENT -			WES	TUNINST	KR MD	21157	
(BA)	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 2.	32. Regis	ar's Signature					

			1 - For State Registrar	ite of Marylar	nd / Depa		lealth and N	Mental Hyg	piene () () 5	12178
	Physic /Medi	cai	Decedent's Name (First, Middle, Last) WILLIAM H. BOUNDS As. Facility Name (If not institution, give street).					2. Date of Dea Month	th Day Year	
	Examir Funeral	ier	Peninsula Region at 5. Social Security Number 6. Sex	MANUA 7. Age (In yrs.	Unfu last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth		th thplace (State or Foreign puntry)
	Director		220-12-0913	00	Yrs. ity, Town or Lo		Tiodic IIIII.	12-04-19	924 SIL	DAM, MARYLAND 10d. Inside City Limits
	death with the Maryland ms 23e or 28a-f ehow must be rotiff of ≊t	Director	MD WICOMICO 10e. Street and Number	S	ALISBUR	Y 10f. Zip Code		1	0g. Citizen of What Co	1 Tyes 2 No
socials O913	after or Ite	Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐	us Decedent Ever in Uned Forces?] Yes 2 전 No 'es, Give	1	Vas Decedent of H	21801 ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	erican Indian,
12- 215-003	within 72 hours ene. then "naturel", he Medical Era	Completed by	15. Decedent's Education (Specify only highest grade comp	ar or Dates:	16a Deced	lent's Usual Occup		king	Specify:	WHITE /Industry
12.71, 220 and 21	nd 2 should be filed withir sith and Mental Hygiene. 27 Ie marked other then r treumatic event, the Ms	To Be Con	7 17. Father's Name (First, Middle, Last) WILLIE E. BOUNDS			FARMER	18. Mother's Nam		FARMIN Maiden Sumame)	IG
e, Mary	s 1 and 2 shou of Health and M item 27 le mar other treumat	-	19a. Informant's Name/Relationship (Type, Pri DENNIS BOUNDS — SON		405 E	. WALNUT	and Number or Rui	DELMAR,	, City or Town, State, A	1875
Baltimore,	trent o		20a. Method of Disposition 1 XBurial 2 Cremation 3 Remova 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	I from State	OAM CE	nato <i>ry</i> or other plac METERY	03-3	1-2005 s	ILOAM, MAR RAL HOME,	YLAND
ä	permi Depar Impor any ir		23a. Part. Enter the disease, or complications spock, or heart failure. List only one caus	s that caused the deat	/0.	EAST MA	IN STREE	T,SALISB	URY, MARYLA	ND 21804 Approximate Interval Between Onset and Death
68760,	or Attending Physicien: The law requires that the death certificate be executed the death. If the death. In physician and infector, page 2 should be detached for use as the burial-transit.	edical Examiner	Sequentially list conditions, ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	HYPOXIA Sue to (or as a consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive t	// A uence of):					Onset and Death
P.O. Box	that the death certifica led by the attending ph detached for use as the	Physician/Med	in the past 12 months?	es, outcome of pregna Live birth 2 ☐ Feta Pregnant at time of d Unknown	ıl death 3 □	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	w requires that been signed b should be deta	ted by PI	Part II. Other significant conditions contribution HYPELTENSION						acco use contribute to s 2 □ No 3 □ Pro	the cause of death?
al Rec	icien: The law certificate has b rector, page 2 sh	e Completed by	CHRONIC DISTRUCTION	JE YULM	OWARY	DISEA	458	24a. Was ar autopsy perform 1 Ves 2	prior to d	topsy findings available completion of cause of 200 No
Division of Vital Records,	ttending Physicien: death. stor: After this certific r the funeral director,	To B	2 ☐ Accident investigation	1 Propatient 2 Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	4 Nursing Ho		nce 6 Other (Spec	eify)
Divis	Hospital or Attend 24 hours after deatl Funerel Director: tely filled in by the	l Certification;	4 Homicide	Place of Injury - At he building, etc. (Specif	y) 			City or Town,		
	To the Hospital or Al within 24 hours after or To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one) 2 ☐ Medical Examiner: Or and and and and and and and and and and	the basis of examina d manner stated	wiedge, death ition and/or inve	occurred at the timestigation, in my op	inion, death occurr	ed at the time, da	use(s) and manner as te and place, and due d. Date, signed (Month	to the cause(s)
	in		30 Name and address of person who complete	d cause of death (Item	1 23a) (Type, P	D-0	060513		3/28/0	5
	Sta		1. THIMMANATAPPA 31. Date filed (Month, Day, Year)	MD 614	B EA	STERN SHO	RE DR	SALISB	MAY MID	2/804
	Registra	ar	MAR 2 9 2005	Slower	15. 16	parle				

		•	State of Maryland / E		Health and N	lental Hygie	_	12179	
	Physici	cal	1. Decedent's Name (First, Middle, Last) Mary Lois Bramble			2. Date of Death Month /	Day Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Dorchester General Hospital 4b. City, Town, or Location of Death Cambridge			4c. County of Death Dorchester		ith	
	Funeral Director		5. Social Security Number 220-52-0485 Usual Residence of Decedent	thday) tf Under 1 Yea Months Day		8. Date of Birth (Month, Day, March 12	^{9. Bir} , 1915 Ma	thplace (State or Foreign ountry Lry Land	
5	e Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town Maryland Dorchester	woolford				10d. tnside City Limits 1 ☐ Yes 2 ☑ No	
Z	th with th 23a or 26 Ist by no	Funeral Director	10e. Street and Number 1611 Taylors Island Road	10f. Zip Code 21	1677	10g	. Citizen of What Co USA		
920	illed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be mulified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Moli Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	of Hispanic Origin? (Spuban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh		
Maryland 21215-0036	s 1 and 2 should be illed within 72 ho f Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, Ite Medical	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	ne during most of work	ing 16	b. Kind of Business Own Home		
/land 2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ire M	To Be C	17. Father's Name (First, Middle, Last) Frederick Asplen Bramble		18. Mother's Nam	e (First, Middle, Ma ie Parker			
	tnd 2 sho alth and 1 27 Is ma er traume		19a. Informant's Name/Relationship (Type, Print) 19b. Solomon F. Bramble, III/Grands on	Mailing Address (Street 1611 Taylo					
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other tra ances.	3	1 McBuriai 21 Gramation 31 Bemoval from State 1	Disposition (Name of y, crematory or other p inity Cemet			c. Location - City or hurch Cre		
Balt	permit. Departr Import. any inj		21. Signature of Pineral Service Licensee **DUKRAK		ress of Facility romwell Fu St., Camb				
8760,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed to the Wilhin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of be being the funeral director.	dical Examiner	23a. Part. Enfer the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions) Due to (or as a consequence of the conditions) Due to (or as a consequence of the conditions).			Approximate Interval Between Onset and Death Comm			
P.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetat death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnar 5 □ Other (specify)			23d. Date of de Month	livery Day Year	
		ē	Part II. Other significent conditions contributing to death but not resulting in	the <i>u</i> nderlying cause o	given in Part I.			o the cause of death?	
Vital Records,		atlon: To Be Completed				24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of	
Division of Vita			27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. 1 2 Accident investigation	Time of 28c. In Hury W	Other: 4 Nursing Ho	h (Check only one) ome 5 Residenc 28d. Describe how		· rcify)	
Divis		Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury : At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		Medical Certification:	29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge 2 Madical Examiner: On the basis of examination an and manner stated.			red at the time, date	and place, and due	e to the cause(s)	
		Σ	29b. Signature and title of certifier Multiple Color MD	29c. Lice	>638	29d	Mach 7	th, Day, Year) 8 2-00 5	
			30. Name and address of person who completed cause of death (Item 23a) Milchnel Paddew MD 30 3	Type, Print)	, Herlock	md 216	43	8 2005	
	Sta Registi		31. Date filed (Month, SIAR ^{ar)} 2 9 2005 ³² . Registrar's Signature	Specific					

			For	State of Man				ental Hygi	ene 0 0 5	12180
			State Registrar		Cei	rtificate of	Death		g. No.	S Fire of Doort
	Physici		1. Decedent's Name (First, Middle, Last		0	1 -		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Alfred	Jerome	Burr		JR.	9_ 0	22 200 4c. County of Dea	
	Examin	er	4a. Facility Name (If not institution, give	. /	7-1	1 - L	or Location of Death		Driche	Stor-
			Dorchester Ges 5. Social Security Number 6. Se	nerd Hosp	n yrs. last birthday)	If Under 1 Year		8. Date of Birth	9. Bir	thplace (State or Foreign
	Funeral Director			M 2DF	79 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		ountry) aryland
		-	Usual Residence of Decedent		/_/_			10-01,1	70,0,1,0,	
	ours after death with the Maryland ral', or items 23a or 28e-f show Evanirer must be notified at		10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
\supset		tor	MD Dorch	ester	Cank	Ridge				1 DYes 2 No
2		lrec	10e. Street and Number			10f. Zip Sode		10	g. Citizen of What C	ountry?
2		Funeral Director	824 Pine	Stree	+	21	613		USA	
0	r dea	ıner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe oan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	or It	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tryes 2 No If Yes, Give	1944	1 ☐ Yes 2 ☑ No	Specify:		Specify:	/ .
5-0036	within 72 hours after ene. then "netural", or Ite	g p	3 Widowed 4 Divorced 15. Decedent's Ed	Year or Dates:	1946	dent's Usual Occu	nation		16b. Kind of Business	Ω C K √Industry
	n 72 n nel	Completed	(Specify only highest grad	de completed)	(Give	kind of work done DO NOT use retire	during most of worki ed)	ng		
121	filed withi Hygiene. Ithar than	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Mag	chine	Operat	OR	Manufa	cturing
9	filed Hygie othar ant, II	BeC	17. Father's Name (First, Middle, Last)		777100		18. Mother's Name	(First, Middle, N	faiden Surname)	7
an	Mental Merked c arked c	To B	ALFROD TOR	ome Bur	Roughs	SR,	Nellie	- Reb	ecca +	homas
Mary	of a mile		19a. Informant's Name/Relationship (7		F9b. Maili	ng Address (Stree	t and Number or Rura	l Route Number,	City or Town, State,	Zip Code)
Σ	1 and 2 Health a Ism 27 Is		Alfred S	lacum	824	-Pine		ambric	tge Mari	1/and 2/61
re,	of Health of Health fitam 27 r other tr		20a. Method of Disposition	Dames of from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla			200. Location - City of	Town, State
m	Pages nent of nnt: If it		1 12 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Veterar	s Cemet	ery 3/2	9/05 1	HURIOCK	Maryland
altimore	permit. Pag Department Importent: I any injury c		21. Signature of Funeral Service Licen	see Ol	2	2. Name and Addr IENRY F	ess of Facility	HOME, 1	?. A.	- 11.
Ω	Dep Impe		Janelle (, Henri	X	SIOWIAS	shington	St. Can	IBR. dale,	MD. 21613
	Physician posecuted /Medical Examiner		23a. Part Enter the disease, or comp shock, or heart failure. List only	plications that caused the one cause on each line.	edeath. Do not en	ter the mode of dy	ing, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
			Immediate Cause (Final disease or condition	a Cerebi	ral ho	emori	hage			1-2 das
4			resulting in death)	Due to (or as a				, ,		11 /2 =
н			Sequentially list conditions,	b. aereb.		scula	r acci	dent		10 days
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						15/100	
		хап	that initiated events resulting in death) Last Cause (Disease or Injury that initiated events resulting in death) Last Due/of (or as a consequence of):					70 9003		
60,		calE		. And s	tage	renal	dise	JCC		
687	eath certificate be exattending physician for use as the buria	_		d	/ /					
×	certificat nding phy use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of de	elivery
Вох	leath atter	clar	in the past 12 months?	1□Live birth 2 4□Pregnant at tir		□Ectopic pregnand □ Other (specify) _	cy 		Month	Day Year
P.O.	iaw requires that the death as been signed by the atten 2 should be detached for u	hysi	9 Unknown	9□ Unknown						
		by Physiclan/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?			
Records,		ed	Cardiom	40 pathe	1			1 U Ye	s 2 No 3 F	Probably 4 Unknown
CO	awre	plet		, ,				24a. Was a autops	v prior to	utopsy findings available completion of cause of
Ä	ding Physician: The Ing. After this certificate his funeral director, page	Completed						perform	ned? death?	s 2 No
Vital		BeC	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	θ)	
f <		To	1 ☐ Yes 2 ☐ No	Hospital: 1 ☑Inpatient		nt 3 DOA			ence 6 Other (Sp	ecify)
0 [27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day)	/ear) 28b. Time (W		28d. Describe no	w injury occurred	
sio		catl	2 Accident investigation 3 Suicide 6 Could not be		A. b		Yes 2 No	28f Location /St	reet and Number or F	Rural Boute Number
Division of	or Ati	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	(Specify)	reet, ractory, office	9	City or Town	, State)	idiai i lodio i vambor,
	Hospital 4 hours a Funeral C									
		Medical	(Check only 2 Medicel Exert	niner: On the basis of e	xamination and/or it	nvestigation, in my	opinion, death occur	red at the time, d	ate and place, and du	e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				nse number		9d. Date signed (Mor	
	F > F 0		D. Bahneson	250		Ho	05997-	3	9-23-0	05
			30 Name and address of person who	-00	ith (Item 23a) (Type	. Print)	NI	1-1	100	
Potolicie Johnson 100 Bramble St Cambridge								age 1	ni) 216	13
		ate	31. Date filed (Month, Paux Kar) 2. 5	2005 32. Registrar	s Signature					
	Regist	rar	X2 01 20 0		was fit	A TOP OF				

BRODSK

			1 - For State Registrar		laryland / Dep	artment of Health ar	_	/giene)E 19109
			Hegistrar Decedent's Name (First, Middle, La	st)		Tillicate of Death	2. Date of De	Reg. No. U	3, Time of Death
	Physic		Alma Ethel Britz	,			Month March	Day	Year 005 6:15 P ^M
	/Medi Examir		4a. Facility Name (If not institution, give	e street and number)	4b. City, Town, or Location of		4c. County	
			10106 Parkwood T	errace		Bethesda		Montg	omerv
	Funeral		5. Social Security Number 6. 5	Sex 7. A I □ M 2 X F	ge (In yrs. last birthday	Months Days Hours	Hrs. 8. Date of Bi		Birthplace (State or Foreign Country)
	Director		400–18–2217 Usual Residence of Decedent	ICIM ZIALF	85 Yrs.		05/05/	1919	Kentucky
	land ow		10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits
	Mary Fred	ţō	MD Montgom	erv	Bethesda				1 ☐ Yes 2 X No
	r 28e	irec	10e. Street and Number	er y	Dechesda	10f. Zip Code		10g. Citizen of W	/hat Country?
	23e o 23e o	alD	10106 Parkwood T	errace		20814		U.S.A.	
	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-f show he Madical Examinar must be notified at	by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	n? (Specify Yes or No	0- 14. Race	- American Indian,
36	or It	y FL	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 X	No	1 ☐ Yes 2 X No Specify:	3010 1110411, 0(0.)	Specify:	k, White, etc.
Ö	hour turel'	q pe		Year or Dates:	160 000				MITTE
75	in 72	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give	dent's Usual Occupation a kind of work done during most o DO NOT use retired)	of working	16b. Kind of Bu	siness/Industry
212	d with piene.	om	Elementary/Secondary (0-12)	College (1-4or	5+)	emaker		Own Ho	me
פַ	e filec othe vent,	Be C	17. Father's Name (First, Middle, Last,)		18. Mother's	Name (First, Middle		
<u>la</u>	uld b Menta rrked trice	To E	Clyde Wheeler			Flauc	lie Long		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or items 23e or 28e-f show minuty or other treumatic event, the Madical Examination at the notified at Once.	i	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ng Address (Street and Number of	or Rural Route Numb	er, City or Town, S	State, Zip Code)
	and ealth m 27		Diane Britz, Daug	ghter		6 Parkwood Terr	ace, Bethe	esda, Mar	yland 20814
Baltimore,	H ite		20a. Method of Disposition 1 □ Burial 2 XCremation 3 □	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place)	Date	20c. Location - 0	City or Town, State
Ē	tent:		`4 □Donation 5 □ Other (Specif	y)	Ft. Lince	oln Crematory O			od, Maryland
Ba	permil Depar Impor Impor eny ir		21. Signature of Fu leval Service Licer	isee		2. Name and Address of Facility			
		\dashv	23a. Part1. Enter the disease, or com	on Uz		040 Rockville F			
10	S 7=		shock, or heart failure. List only Immediate Cause (Final	one cause on each i	ine				Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		age Arterio	sclerotic Cardi	iovascular	Disease	
9	Examiner			Uwaarta					
		Jer	Sequentially list conditions, if any leading to immediate		a consequence of):				
	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c					
o O	ate be executed hysician and the burial-transif		resulting in death) Last	Due to (or as	a consequence of):				
8760,	certificate be executed ding physician and ise as the burial-transif	lical		d					
Q X	eath certifica attending ph for use as t	Physician/Med	IF FEMALE:	00-14	WE ARREST				
Вох	atter for u	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy		23d. Date Mont	of delivery th Day Year
	0 0 0	yslc	in the past 12 months? 1 □ Yes 2 ♣No 9 □ Unknown	4∏Pregnant a 9∏Unknown	t time of death 5 L	Other (specify)			Day Tou.
_	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions c	ontributing to death b	out not resulting in the u	nderlying cause given in Part I.	23e. Did t	obacco use contrit	oute to the cause of death?
ecords,	uires n sign ld be	Q	Parkinson's Dise						3 Probably 4 □Unknown
Ö	w require been signature should b	lete	Osteoporosis				24a, Was	an 24h W	era autoneu findinge available
T E	0 5 0	Completed	<u> </u>				— autor	osy pro	ere autopsy findings available for to completion of cause of eath?
	sicien: The certificate irector, pag	Be C	Gastroesophageal 25. Was case referred to medical	Reflux		OC Diago of	1 ☐ Yes Death (Check only of	- 23	☐Yes 2☐No
	Physicien: this certific	0	examiner? 1 ☐ Yes 2 🙀 No	Hospital:	ent 2 ER/Outpatie		ng Home 5 Resid		(Spacifu)
_	5 9 9	i i	27. Manner of Death	28a. Date of Inju (Month, Da		28c. Injury at Work?	28d. Describe	now injury occurred	d
0	Attending I r death. ector: After by the funer	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		y Year) Injury	M 1 Yes 2 No			
DIVISION		Certification	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home, farm, street, (Specify)	eet, factory, office	28f. Location (S City or Tov	Street and Number	or Rural Route Number,
	spitel or ours after nerel Dia filled in	Cer							
	To the Hospitel within 24 hours a To the Funerel I completely filled	ical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best niner: On the basis o	of my knowledge, deat f examination and/or in	occurred at the time, date and p vestigation, in my opinion, death o	lace, and due to the	cause(s) and mani	ner as stated.
	thin 2 the mplet	Medical	29b Signaturarand title of contifie	and manner sta	ated.	29c. License number			
	F X F 8	-	1 4 4	MIII.	anguage agraphic decreed	H45839		March 25	(Month, Day, Year)
	5	-	30. Name and address of person who		leath (Ita = 00:1 =			naich 2)	, ZUUJ
			Gary E. Raffel, Do			·	202A - Ro	thesda. N	m 20814
	Sta	e	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	_			
	Registra	ar .	MAD 2 8 20	05 6	IX Can	ale .			

			For State Registrar	State of M	aryland		artmen <i>tificate</i>			and M		giene Reg. No.2 (005	12183
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Edgar Bywaters BAF								2. Date of De Month	Day	Year 2005	3. Time of Death P
	Examin	er	4a. Facility Name (If not institution, give)				Location o				nty of Deat	
	Funeral		Washington County 5. Social Security Number 6. Sec		ge (In yrs. las	st birthday)	If Under	1 Year	If Under		8. Date of Bir		hingt	
	Director			M 2□F	81	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da Jan. 7	y, Year) ,1924	Mar	hplace (State or Foreign untry) yland
	pu k		Usual Residence of Decedent 10a. State 10b. County		100 City	Town or Lo	antina			•				
	Aaryla F sho	٥	Maryland Washingt	on		ersto								10d. Inside City Limits 1X Yes 2 □ No
	the N	rect	10e. Street and Number	.011	IIag	EISLU	10f. Zip	Code		_		10g. Citizen o	of What Co	untry?
	h with	i Di	121 East Lee Str	eet				217	40			USA		,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or Items 23e or 28a-f show any injury or other treumatic event, the Modical Examinating must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ⊠ Yes 2 ☐ If Yes, Give Year or Dates:	No No		Was Deced f Yes, spec		spanic Origin, Mexican	gin? (Spe	ecify Yes or No Rican, etc.)	- 14. F E Spe	Black, White	rican Indian, a, etc. rhite
21215-0036	72 hou	ted	15. Decedent's Edu	cation		16a. Deced	ient's Usua	Occupa	tion			16b. Kind of	Business/	Industry
218	thin 7 e. man "n Med	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wor DO NOT us			t of workii	ng			
21	led wilygien her th		8	0		cons	ole b	uild			(5)		e org	an
Maryland	d be fi	Be	17. Father's Name (First, Middle, Last) unknown								(First, Middle, ae Bywa		ame)	
Ž	should nd Me mark imatic	ဥ	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	g Address	(Street a			l Route Numbe		vn. State. Z	ip Code)
	alth ar 27 is 37 is		Madlyn L. Baer -											nd 21740
ore,	of Hei	. 1	20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ F	lama val fas m Ctata	1 000	ce of Dispo	sition (Nam	e of her place	9)	D	ate	20c. Locatio	n - City or	Town, State
altimore,	Page ment ant: It ury o		'4 □Donation 5 □ Other (Specify)	emoval from State	1	Hil:				4/1/	05	Hagers	town,	Maryland
Balt	permit. Depart Import any inj		21. Signature of Eureral Service Licens	Mus	me	11	Name and				MINNICH , Hager			
			23a. Part1. Enter the disease, or compf shock, or heart failure. List only or	cations that caused ne cause on each li	d the death. ine.	Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory ar	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	51	PSis									Criser and Death
п	/Medical Examiner		1	Due to (or as	a conseque									
	DATE.	er	if any, leading to immediate	Due to (or as		nce of):							-	
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	R	ena	F	aila	1.						
Ő,	cate be executed physician and the burial-transit	Ex	resulting in death) Last	Due to (or as	a conseque	nce of):								
8760,	physic physic s the b	dica						-	_	-				
P.O. Box 6	death certif e attending d for use a:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal de	eath 3	Ectopic pre Other (spe						Date of deliment	very Day Year
	es De	٥	Part II. Other significant conditions cor	itributing to death b	out not resulti	ng in the ur	nderlying ca	iuse give	n in Part I.		1	obacco use co		the cause of death?
Sor	w requir been si should	etec									24a. Was			
Division of Vital Records,		Completed									autop perfo		prior to c death? 1 Yes	topsy findings available ompletion of cause of
Ξ	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:		2/0		Othe			(Check only o			
of	a Phy er this	F 45	27. Manner of Death	28a. Date of Inju	ıry 2	∛Outpatien 8b. Time of		Bc. Injury Work	4 LINUI		ne 5 🗌 Resid 28d. Describe h			ify)
ion	Attending r death. ector: After by the fune	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	М		? ′es 2 □ N	No				
Divis	al or Atte s after de al Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	jury - At homic. (Specify)	e, farm, str	eet, factory	office		2	28f. Location (S City or Tow		mber or Ru	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edicai (29a. Certifier 1 Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best ner: On the basis o and manner st	f examination	edge, death n and/or inv	occurred a restigation,	it the time in my op	e, date and inion, deat	d place, a	and due to the ded at the time, d	cause(s) and date and place	manner as e, and due	stated. to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Menhan			29c.	License	number O (, 0	396	Ś	29d. Date sign	oned (Month	Day, Year)
SH	1.5+1			MSHED		За) (Туре,	Print) \	126 Ha	gerst	pal pal	(» · · · ·	J 51.	740	
	Sta Registr	te ar	31. Date filed (Months Day Year)	32. Registr	ar's Signatur									

			_ For	1 icase	-	f Marylar						-			
			1 - State Registrar				-	rtificat				-	Reg. No.	2005	12184
ı	Physici	an	Decedent's Name (i	First, Middle, Las	t)							2. Date of De Month	Day		3. Time of Death
	/Medic Examin	al	Bernard Da 4a. Facility Name (If no			mber)		4b. City,	Town, or	Location of	of Death	03	2C	County of Death	
	LAGIIIII	CI	Sacred	1 1 1	P 3 -	oital		Ci	mp	. 1	ind	_		Allegan	
	Funeral		5. Social Security Num	1	x MM 2□ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birth Cou	nplace (State or Foreign untry)
	Director		214-28-6291 Usual Residence of Do	ecedent		74						_27-Sep-	1930	Mary	land
	arylan show	_	10a. State 1	0b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	the Mi	Director	Maryland 10e. Street and Number	Allegar	<u>y</u>	Fros	tburg	10f. Zîp	Codo				10a Citi	zen of What Cou	1 X Yes 2 □ No
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or Items 23a or 28a-f show avant, the Mydical Evairitier must be rigitled at		106. Stiest and Humb	15 Hawth	orne Driv	е		215					U.S. /		antry :
	ems 2	Funerai	11. Marital Status		12. Was Dec	edent Ever in U	.S. 13.			spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Amer Black, White	
30	s after	by Fu	1 Never Married 3 Widowed 4 [,	1 ☐ Yes If Yes, Gi Year or □	2 No ve	1	1 □ Yes		Specify:		10411, 0101,		Specify:	
9500-61212	2 hour	ted b	15	5. Decedent's Ed	ucation	vates:	16a. Dece	dent's Usua	al Occupa	ition			16b. Ki	White	
2 2	thin 7: ien n	Completed	(Specify Elementary/Second	only highest gra ary (0-12)	de completed) College (1-4or 5+)	16a. Dece (Give life.	kind of wo DO NOT us	rk done d se retired)	<i>luring</i> mosi)	t of workii	ng			
_	iled w Hygien thar th		12 17. Father's Name (Fit	ret Middle Last)			powde	er oper	ations			(First, Middle		stics labor	ratory
yland	be d o	To Be											, Maiden	Sumame)	
Mary	s 1 and 2 should by f Health and Menta itam 27 is markad other traumatic av	-	Gurney Col		ype, Print)		19b. Mailir	ng Address		Nellie Ind Numbe			er, City o	r Town, State, Z	ip Code)
	1 and 2 Health a lam 27 is		_Dolores Co		wife			vthome			Frost			faryland	21532
ващтоге,	e = 5		20a. Method of Dispos	Oremation 3 🗆			Place of Dispo cemetery, crea	sition (Nar. natory or o	ne of ther place	9)	-	ate		cation - City or T	Town, State
	- a -		* 4 ☐ Donation 5			Fro	stburg M	emorial 2. Name an		s of Facilit		[ar-2005]	Frostb	ourg M	laryland
ñ	permit, Departi Import eny inj		100	in R.	Du	est					•	oct Ava	Fron	tburg MI	21522
	10		23a, Prt1. Enter the shock, or heart for	disease, or comp ailure. List only (lications that	caused the deat	h. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,	totag, wit.	Approximate Interval Between
	Physician		Immediate Cause (Fir disease or condition resulting in death)	nal	a	ENAL	FAIL	IRE						Ac	Onset and Death
	/Medical Examiner		resulting in death)		Due to	(or as a conseq			-						16.21
		Jer	Sequentially list condi	tions. ediate	b. Due to	(or as a conseq		MELL	() a s					36	5W Lyear
	nd nd transit	Examiner	Sequentially list condi- if any, leading to immediate. Enter Underlyi Cause (Disease or inju- that initiated events	ury	c										
/60,	ate be executed nysician and he burial-transit	cai Ex	resulting in death) Las	St.	Due to	(or as a conseq	uence ol):								
28	ficate g phys			•	d										
X Q Q	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pr	egnant		tcome of pregna		Ectopic pr	egnancy				2	23d. Date of deliv	•
	he dea the att	/sici	in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown			ant at time of d		Other (sp						Month	Day Year
7	that the ed by detac		Part II. Other significa	int conditions co	ntributing to d	eath but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did t	obacco u	se contribute to	the cause of death?
rds	quires nn sign uld be	ed by	Cop	ONARY	ART	TERY	1)11221	e				10,	Yes 2	□No 3□Pro	bably 4 Unknown
Records,	2 55 02	ompieted	Sanc.	many	Rym.	fort						24a. Was			opsy findings available ompletion of cause of
Ĭ	Th ate pag	Com	Joseph			()						perfo	rmed?	death?	·
VItal	Physician: The this certificate ral director, pag	Be	25. Was case referred examiner?		Hospital:				Othe			(Check only o			
0	ding Phys h. After this funeral di	n: To	1 Yes 250 No 27. Manner of Death		28a. Date	Inpatient 2 of Injury	28b. Time of		8c. Injury	at		ne 5 ☐ Resid 8d. Describe I		Other (Special occurred	ify)
loi	anding rath. or; Afte	atio	2 Accident	5 Pending investigation		th, Day Year)	Injury	М	Work 1 🔲 Y	? ′es 2 □ l	Vo				
UNISION	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	280. Place	of Injury - At ho ing, etc. (Specif	ome, farm, str	eet, lactory	, office		2	8f. Location (S City or Tox	Street and vn, State)	d Number or Rur	al Route Number,
3	spital ours a		29a. Certifier	Certifying Ph	sician: To the	best of my kno	swiedne dealwo	n occurred	at the time	e date and	d place a	nd due to the	rause(s)	and manner as	hateta
	n 24 h na Fur bletely	edical	(Check only 2 one)	Medical Exam	iner: On the b	asis of examina ner stated.	tion and/or in	vestigation	in my op	inion, deat	th occurre	d at the time,	date and	place, and due t	to the cause(s)
	To the Hospital or Attending Pl within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Me	29b. Signature and titl	-					. License					signed (Month,	
	5		•	Hudhin					26	907			MAY	CCH 21	2005
	nes		DR. Harri	Sol person who o	ompleted cause	se of death (Item	n 23a) (Type, Walsh	Roal	o, c	omb	er la	ind, h	a	21502	
	Sta	te	31. Date filed (Month,		32. F	pistrar's Signa	turo	A		3,					•
	Registr	ar	M	AR 212	005	The same	31 6	J.S. Jan							

DHMH 17 Rev 1/2001

		For State Registrar		-	epartment of Certificate o			Reg. No.	12185
sicia		1. Decedent's Name (First, Middle, Las Charles O. (Month MARCH	Day Year	3. Time of Death 7:16 A. M
ledic amin		4a. Facility Name (If not institution, give			4b. City, Town	, or Location of Dea		4c. County of Dea	
		VA MARYLAND HEALT	TH CARE SYS	TEM	H	PERRY POI		CEC	_
eral		5. Social Security Number 6. S	FIM 2FF	In yrs. last birth	day) If Under 1 Year Months Day	r If Under 24 Hr s Hours Mir	S. 8. Date of Birl (Month, Da	y, Year) 9. Bi er 29, 192	rthplace (State or Foreign country)
tor		219-16-5626 Usual Residence of Decedent	8	0 '			Novembe	er 29,192	4 MD
		10a. State 10b. County	1	0c. City, Town	or Location				10d. Inside City Limits
	Director	MD Cecil		Ches	apeake C				1 ☐ Yes 2万 No
		10e. Street and Number			10f. Zip Code			10g. Citizen of What C	country?
	Funeral	2640 Augustii	ne Herman 12. Was Decedent Eve			915 f Hispanic Origin? (Specify Yes or No	U.S.A.	erican Indian.
		1 Never Married Married	Armed Forces? 1 XYes 2 ☐ No		13. Was Decedent o		irto Rican, etc.)		ite, etc.
ŀ	aby	3 ☐ Widowed 4 ☐ Divorced		1943-	1 ☐ Yes 2 🔯 N			Specify: W	hite
1	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	1943 _{6a. [}	Decedent's Usual Occ Give kind of work dor life. DO NOT use reti	upation ne during most of w	orking	16b. Kind of Business	s/Industry
	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		ostal Ca	rrier		II.S. Pos	tal Servic
	0	17. Father's Name (First, Middle, Last)			OBOUT CO		ame (First, Middle,	Maiden Sumame)	our bervie
	To B	Charles J	. Critchle	ey		Helen	Orem		
		19a. Informant's Name/Relationship (7	Type, Print)	19b.	Mailing Address (Stre	et and Number or F	Rural Route Numbe	er, City or Town, State,	Zip Code)
		Pauline Critch	ley/Wife			6, Ches		City, MD	
		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery	Disposition (Name of crematory or other p		rch 29.	20c. Location - City of	
		`4 □Donation 5 □ Other (Specify			ose of I	ııma ¦ 2∩	05	Chesap	eake City,
ouce.		21. Signature of Funeral Service Licen	- 6		ex. Wame and Add Andrew		Funeral	MD Home	
n		23a. Part1. Enter the disease, or a my shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)			259 Fas t enter the mode of d SCULAR DIS		St E1 ac or respiratory ai	.kton, MD	21921 Approximate Interval Between Onset and Death UNKNOWN
al er		resulting in douting	Due to (or as a o	consequence of):				
	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
	al Ex	resulting in death) Last	Due to (or as a o	consequence of):				
	dica		d						
	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of de	diverv
	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 (4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death	3 ☐Ectopic pregnar 5 ☐ Other (specify)			Month Month	Day Year
	by Ph	Part II. Other significant conditions of	ontributing to death but r	not resulting in	he underlying cause	given in Part I.	23e. Did to	obacco use contribute t	to the cause of death?
	ed E	CAROTID ARTERY D	ISEASE				101	Yes 2□No 3□P	robably 4X1Unknown
	plet						24a. Was	an 24b. Were a	utopsy findings available completion of cause of
	Completed						perfo	rmed? death?	s 2 No
	Be	25. Was case referred to medical examiner?	Hamitol.				eath (Check only o	ne)	
	ဂ္	1 ☐ Yes 2X No	Hospital: 1 Inpatient		atient 3 DOA		7-	dence 6 Other (Spe	ecify)
	tion	27. Menner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. Tii Inj	ury W	juryat łork? □Yes 2 □No	∠au. Describe h	now injury occurred	
	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		- At home, farr (Specify)	n, street, factory, offic		28f. Location (5 City or Tox	Street and Number or R vn, State)	Rural Route Number,
	edical C	29a. Certifier (Check only one) Check only 2 Medical Exam	ysician: To the best of a niner: On the basis of ea and manner state	camination and	death occurred at the or investigation, in m	time, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
- 1	Med	29b. Signature and title of certifier	PA	1	29c. Lice	nse number		29d. Date signed (Mon	th, Day, Year)
			/ /	. // .					
		•	171	ty ?		D19402		MARCH 25,	2005

ORIGINAL

		1	1 - For State of Maryland / Department Certification	nt of Health and M te of Death		giene 005	12186
	0		Decedent's Name (First, Middle, Last)		2. Date of Dea	th	3. Time of Death
Н	Physici /Medic		Jean Haslam Connell		March .	25, 2005 Year	20:10 PM
	Examin			, Town, or Location of Death		4c. County of Death	
				estertown		Kent	
	Funeral Director		135-70-4902 1 M 2 F 86 Yrs. Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day January	21,1919 9. Birthp	lace (State or Foreign ntry)
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			11	0d. Inside City Limits
	f sho	ō	MD Queen Anne's Church Hil	1			1 X Yes 2 □ No
	28a-	Director		p Code		10g. Citizen of What Cour	ntry?
	3a or	Ö	532 Main Street 21	623	1	USA	
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dece Armed Forces? 13. Was Dece	dent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Americ	
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Madical Examinar must be notified at	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes		ricari, etc.)	Black, White, Specify: Whi	
ò	2 hou		15. Decedent's Education 16a. Decedent's Usu			16b. Kind of Business/Inc	dustry
215	thin 7 e. an "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+) (Give kind of we life. DO NOT u	ork done during most of workir use retired)	ng	0 11	
2	ygien ygien rer th	Co	4 Homemake			Own Home	
nd	be fill d oth	Be	17. Father's Name (First, Middle, Last) Herbert Haslam	18. Mother's Name	<i>(First, Middl</i> e, : t Kendr:		
ž	hould d Mer narke natic	2		s (Street and Number or Rura			Codel
Ma	id 2 sl ith an 27 is r traur			Street, CHurch			Code)
ē,	s 1 an f Неа item 3		20a. Method of Disposition 20b. Place of Disposition (Na	me of D	-	20c. Location - City or To	wn, State
E	Page: ient of nt: # ir		1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	emation March	28,2005	Stevensvill	e, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Examinational Lianobilised at ODGs.		21. Signature of Funeral Service Licensee Fe 11 own	nd Address of Facility s, Helfenbein eer Road, Ches	& Newna	am Funeral H	lome, P.A.
	_		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the modern				Approximate
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ne		~	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	173			-2 hrs
	Examiner		Sequentially list conditions, b.				
	pa iii	iner	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury				
	and I-trans	Examiner	Causs (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			-	
8760,	cate be executed physician and the burial-transit						
687	ficate physics the	edical	d.				
Вох	eath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ery
	that the death ned by the atter detached for t	by Physiclan/Me	in the past 12 months? 1 Yes 2 No 1 Vegrant at time of death 5 Other (st			Month	Day Year
<u>Ф</u>	at the by the stache	hys	9 □ Ouknown				
Records,	gr		Part II. Other significant conditions contributing to death but not resulting in the underlying of	ause given in Part I.	23e. Did to	bacco use contribute to the es 2 ☑No 3 ☐ Prob	ne cause of death? ably 4 □Unknown
00	aw requir as been si 2 should	Completed			24a. Was a	n 24b. Were auto	psy findings available
8	The lavate has page 2	mo			autops perfori	med? death?	npletion of cause of
Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred medical examiner?	26. Place of Death	(Check only or		
<u>Š</u>	d is	ဥ	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ Do		ne 5 Reside	ence 6 Other (Specify	()
Division of	ing l	lon:	N. Carlotte	28c. Injury at 2 Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurred	
S	death ctor: A	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factor		28f. Location (Si	treet and Number or Rura	l Route Number.
<u>≥</u>	in the se	Certification:	4 Homicide determined building, etc. (Specify)	,,	City or Town	n, State)	
	To the Hospital or within 24 hours after to the Funeral Director completely filled in I	edical	29a. Certifier (Check only Madical Examiner: On the basis of examination and/or investigation	at the time, date and place, a n, in my opinion, death occurre	and due to the cand at the time, d	ause(s) and manner as st ate and place, and due to	ated. the cause(s)
	To the within To the comp	ž	29b. Signature and the of certifier 29	c. License number	2	9d. Date signed (Month, I	Day, Year)
			JOHN STONE OF	D3601 A		03-28-6	5
			30. Name and address of person who completed cause of death (Item 23a) (Type Print)	Rd Rid	ORI	masta da	Dia MAD
	Sta	te	31. Date filed (Month, Day, Ygar) 32. Segistrar's Signature	14.010	y v c	NUTERIOU	71/200
:	Registr		31. Date filed (Month, Day, Year) WAR 2 8 2005 32. Egistrar's Signature	,			LIUAU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year Lowella M. Colman 28 larch 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gr If Under 1 Year If Under 24 Hrs. orcheste 1105 60 vchester neval 8/Date of Birth (Month, Day, Year) 4, 1918 Social Security Number 7. Age (In yrs. las birthday) **Funeral** Birthplace (State or Foreign
Country) 1 M 2 F Days Months Hours 491-09-7184 87 Director Missouri Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinations to use the multified at 1 Yes 2 No Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Jenkins Creek Road 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by Specify 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Thomas H. Foster Elizabeth Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David T. Colman/Grandson 19 Jenkins Creek Rd., Cambrid e, MD other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 6 1 Burial 2 Cremation 3 Removal from State = 5 permit. Page Department of Important: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 04/02/05 St. Joseph, Missouri 22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 21. Signature of Suneral Service Licensee Pm1. Enfer the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death discole Immediate Cause (Final Coronery Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate and the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of). attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1□ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician; after death Director: within 24 hours a

Baltimore, Maryland 21215-0036 o

Registrar

State

2

Certification:

Medical

this

After

1 Yes 2 No

5 Pending

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THANWY

6 Could not be determined

27. Manner of Death

Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

NOMAN

31. Date filod (Month, Day, Year)

AURORA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 00

Wasters-

2005 Registrar's Signature

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

E Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ST

1 ☐ Yes 2 ☐ No

47924

CAMBRIDGE

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 3.28.05

28a. Date of Injury (Month, Day Year)

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend Item 5 per fn 8846 8-8-05 VI
State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 23^{pay} 2005^{ear} **Physician** 11:11 ам Lora C. Cullen /Medical 4a. Facility Name (If not institution, give street and number) Makepeace 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot 26348 Arcadia Shores Circle Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 20, 1 Birthplace (State or Foreign Country)
 New York 6. Sex 7. Age (In yrs. last birthday) 5. **\$234**5**836×19427 Funeral** 1 □ M 2 🖫 F Months Days Hours Yrs. Director 98 1906 221-03-9439 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits 10b. County other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Talbot Easton Maryland Directo 10e. Street and Number Makepeace 10f. Zip Code 10g. Citizen of What Country? 26348 Arcadia Shores Circle 21601 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 10 No 1 Never Married 2 Married 1 ☐ Yes 2 € No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administration Industrial Supply 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John W. Cramer Edith Hudnutt P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Veasey Cullen/Daughter 2104 Weatherstone, Dr., Paoli, PA, 19301 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ö permit. Page Department of Importent: ff any injury or WoodlawnMemorialPark 06/10/2005 Easton, Maryland injury o 4 □ Donation 5 □ Other (Specify) Curran-Bromwell Funeral Home, P.A.

KING High St., Cambridge, MD 21613 21. Signatura of Funeral Service Consee Weed Htorrad-Rand. Enter the dise se, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 30 min Immediate Cause (Final CARDIAC FALLURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner KESPIRATORY Aluke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit neumonia Due to (or as a consequence of): Certification; To Be Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Year in the past 12 months? 1 ☐ Yes 2. No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? be 3 Probably 4 Unknown cleratic cardiovascular 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No Bullous pemphigoid 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A esidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA į 1 Yes 2 No in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation М 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

State Registrar

31. Date filed (Month, Day, Year) R 2 8 2005

Joseph A

30. Name address of person who completed cause of death (Item 23a) (Type, Print)

Bessi Ja



Herofo in Plusician

or 28e-f show

or Items 23a

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: if item 27 is marked other then "neturel", or ite

The law requires that the death certificate be executed

the Hospitel or Attending Physicien:

Division of Vital Records, P.O. Box 68760

and

the attending physician

signed by

peen

this

After

after death Director:

24 hours a

within 2 To the

Baltimore, Maryland 21215-0036

death with the

D60300 Maryhad

March 23, 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. AKA CRISTIAN 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** RISTIAN CALLETAS GIRON 10:55 AM 4 ARCH 2005 19 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number **Examiner** Randolph Hills Nursing Home Wheaton Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1⊠M 2□F Yrs. Director 579-76-5654 83 March 6, 1922 Guatemala Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "neturel", or Items 23a or 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo DC Washington N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 5201 Connecticut Avenue, #503 20015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2□ No Specify: Guatemalan White 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Building Maintenance Federal Government marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fit ment of Health and Mental Hient: If item 27 Is marked ott Justo Callejas Margarita Giron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Callejas/ Granddaughter 7137 Richmond Highway, #155, Alexandria, VA 22306 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 28, ortent: If i 1 Durial 2 Cremation 3 Removal from State permit. Page Depertment o Importent: If any injury or 2005 Gate of Heaven Cemetery 1 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 Part 1. A ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COLON CANCER METASTATIC 2 WEEKS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit the ettending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 Probably 4 Uaknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed? 1 Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Harsing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Watural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 4 hours after death. 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel c within 24 hours af To the Funerel D 1 🗓 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tifle of certifier 30. Name a address of person who completed cause of death (Item 23a) (Type, Print) ANURADHA ARUM, ALLON 110 Sto. #209 Silvely Mulich, 10 ARUM, M.D. 31. Date filed (Month, Day, Year) gistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2005

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H			iene eg. No. 200	5 12190
	Physici		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	th Day Ye	
	/Medic Examir		Evelyn Dorothy Mar 4a. Facility Name (If not institution, give s 4829 Drummond Str	treet and number)			Location of Death	March 23	4c. County of D	
	Funeral Director		5. Social Security Number 6. Sex 506.05.3565	M 2 XF	(In yrs. last birthday) 92 yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day, Oct. 20,	Year)	Birthplace (State or Foreign Country) ebraska
	Maryland e-f show illed at	tor	10a. State 10b. County MD Montgome		10c. City, Town or Lo Chevy (10d. Inside City Limits 1 ☐ Yes ※☐ No
	with the	Director	10e. Street and Number			10f. Zip Code	_	1	0g. Citizen of What	Country?
336	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Itams 23a or 28e-1 show evant. The Medical Examiner must be notified at	by Funeral	4829 Drummond Str 11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Endemed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No		pecify Yes or No- Rican, etc.)		merican Indian, /hite, etc. White
Baltimore, Maryland 21215-0036	filed within 72 hou Hygiene. othar than "nature ant, the Med call	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of world	king	16b. Kind of Busine	ss/Industry
nd;	be filed ntal Hygie od othar evant, II	Be	17. Father's Name (First, Middle, Last) Thomas Cou	£ _ 1				ne (First, Middle, I	Maiden Sumame)	
aryle	should be and Mental s marked o umatic eve	2	19a. Informant's Name/Relationship (Type	2017/2019	19b. Mailir	ng Address (Street a		oara Mare	City or Town, State	e, Zip Code)
Ž,	and 2 lealth a m 27 is		Edward Ryan/ Broth	er-in-law			Street (ase, MD 20	
more	permit. Pages 1 and 2 should Department of Health and Men Important: If Itam 27 is marke eny injury or other traumatic once.		20a. Method of Disposition 1 □ Burial 2 ∑ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of Dispo cemetery, crer	natory or other plac	3/24/		20c. Location - City Alexandria	
Balti	permit. Departmit. Importa eny inju		21. Signature of Funeral Service License	Box		Name and Addres		seph Gawl	er's Son	
	Physician /Medical Examiner	lner	23a. Part1. Enfer the disease, or compliance, or compliance, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	cause on each line Conge: Due to (or as a	he death. Do not ent stive Hear consequence of): L Insuffic consequence of):	t Failure		or respiratory arre	9st,	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	Catas (Disease of Injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
.O. Box 6	that the death certific ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2X No 9 □ Unknown	Bc. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
<u>α</u>	sign d be	þ	Part II. Other significant conditions con Recent Dehydration		not resulting in the u	nderlying cause give	en in Part I.		pacco use contribute	to the cause of death? Probably 4X Unknown
al Records,	The taw ate has b page 2 st	Completed						24a. Was ar autops perform 1 Yes 2	y prior ned? death	autopsy findings available to completion of cause of ? es 2 \(\sum \) No
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	t 2 ER/Outpatien	t 3 DOA Othe		th (Check only on	e) ince 6 □Other (S	(maniful)
ion of	ing After une	atlon: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	The second secon	28c. Injury Work	at	28d. Describe ho		рөспу)
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur- building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Sti City or Town	reet and Number or , State)	Rural Route Number,
	Hospita 4 hours Funara ely fille	edical C	29a. Certifier 1 X Certifying Phys (Check only one)	ician: To the best of er: On the basis of e and manner state	examination and/or inv	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the ca red at the time, da	iuse(s) and manner ate and place, and c	as stated. due to the cause(s)
)		M	29b. Signature and title of partifier			29c. License D0028			March 23,	* * * * * * * * * * * * * * * * * * * *
	10		30. Name and address of person who con E.N. Bodurian, M.		ath (Item 23a) (Type, Wisconsin		Suite 57	5 Chevy	Chase. M	D
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 8 200		's Signature					

Cohen, Nioma 03/22/05 1201 Pm

			1 - For State Registrar	State of M	arylanu / L		rtificate of			iene 0 0 5	12191
	Dhusisi		1. Decedent's Name (First, Middle,	Last)					2. Date of Deat Month	h	3. Time of Death
1	Physici /Medic		NIOMA IDA COHEN						MARCH	22, 2005	12;01 P M
	Examin		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of Death		4c. County of D	eath
			SUBURBAN HOSPIT				BETHESDA			MONTGOME	
	Funeral	1		i.Sex 7.Ag 1□M 2XIF	e (In yrs. last bir 86		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, JUNE 21	Year) 9.	Birthplace (State or Foreign Country)
	Director		195-18-9827 Usual Residence of Decedent			Yrs.		<u> </u>	JUNE 21	, 1918 PI	ENNSÝLVANIA
	land ow		10a. State 10b. County		10c. City, Tow	n or La	cation				10d. Inside City Limits
	Mary -f sh	Ιō	MARYLAND MONTG	OMERY	D	OCIZ	77TTTD				1 X Yes 2 ☐ No
	1 the	Director	10e. Street and Number	OTTERCE		OCK	VILLE 10f. Zip Code		10	og. Citizen of What	Country?
	Multi 38 o		6121 MONTROSE R	OAD			20852				í
	deat	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		merican Indian,
21215-0036	be tited within 72 hours after death with the Maryland ital Hyglene. A other than "natural", or Items 23a or 28a-f show evant, the Medical Examiner must be multihed at	by	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No		r Yes, specify Cuba I⊡ Yes 2. ANo	Specify:	Hican, etc.)	Black, W Specify.WH	
5-0	72 ho	etec	15. Decedent's (Specify only highest	Education	16a.	Deced	lent's Usual Occup	ation	cino.	6b. Kind of Busine	ss/Industry
2	within ene. than *	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	OO NOT use retired	during most of world)	9		
2	filed w Hygier Ither th		43.5.0.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4	4			SALES			RETAIL	
ind	be find Hod other	Be	17. Father's Name (First, Middle, La	ist)				18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
Maryland	should be nd Mental rmarked u	2	BENJAMIN	STEI				SARAH		LDOFSKY	
Nai	12 st h and 7 is n traun		19a. Informant's Name/Relationship							City or Town, State	
	es 1 and 2 should b of Health and Ment: f item 27 is marked ir gther traumatic e		RHODA STEINER/	DAUGHTER					-		FL 33410
Baltimore,	Pages nent of 1 int: If its		1 □ Burial 2 ☑ Cremation 3	Removal from State	l l		sition (Name of natory or other plac	ı		0c. Location - City	or rown, State
ij	it. Partmer rtant njury	. 1	* 4 □ Donation 5 □ Other (Spe 21. Signature of □ al Service Lie		NATION	_	CREMATOR			FALLS CH	
Ba	permit. Pages Department of I Important: If ite any injury or of		21. Signature of the first Service Lin	2		í í	DANZANSKÝ 170 ROCK	-GOLDBERG VILLE PII	G MEMORIA KE, ROCKV	L CHAPEL	S, INC. 20852
			23a. Part1. Enter the disease, or co shock, of heart failure. List or	omplications that caused	the death. Do r						Approximate Interval Between
	Pnysician :		Immediate Cause (Final disease or condition			rorv	Y FAILURE				Onset and Death
	/Medical		resulting in death)	α	a consequence		TALLUKE				24 HOURS
h	Examiner		O	b. PNEUMO	NIA						
	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		a cons quence	of):					
	nd rans	Examiner	Cause (Disease or injury that initiated events	c.							
Ö,	rificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):					
68760,	physic the b	Medical		d.							
		Me	IF FEMALE:	22.5 16.115	-1						
Вох	death cer e attendir id for use	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnancy			23d. Date of o	delivery Dav Year
0	0 0 0	Physician/	1 ☐ Yes 2 🟋No 9 ☐ Unknown	4⊡ Pregnant at 9⊡ Unknown	time or death	5 🗀	Other (specify)				•
۵.	law requires that the as been signed by th 2 should be detache		Part II. Other significant condition	s contributing to death b	ut not resulting in	the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Records,	uires n sign ld be	d by	HEPATIC FAILURE						1 🗀 Yes	2 □ No 3 □	Probably 4 Munknown
CO	w requir been si should	lete	ACUTE RENAL FAII	HDE					24a. Was an	24h Wasa	autopsy findings available
Re	The lay	Completed	ACCIL KENAL FAIR	JOKE					autopsy	prior t	o completion of cause of
Vital	ysician: The Is certificate hadirector, page		25. Was case referred to medical					OR Plans of David	1 Yes 2	A	es a No
5	Physician: r this certific ral director,	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/Ou	tnations	3 DOA Othe		h (Check only one)_ nce 6 □Other (S)	
of	£ -	H- -	27. Manner of Death	28a. Date of Injui (Month, Day	Control of the Contro	ime of	28c. Injury Work	+ La realising file	28d. Describe hov		Decity)
on	Attanding Ir death. actor: After by the funer	at lo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat		y Year) Ir	njury		<br Yes 2□No			
Division	Attaner death	ertification;	3 Suicide 6 Could not determine	ad 286. Flace of inju	ury - At home, fa	rm, stre	et, factory, office				Rural Route Number,
	s afte	Cert	4 THOMICION	building, etc	э. (Эрөспу)				City or Town,	State)	
	e Hospital or Attano 24 hours after death 5 Funeral Diractor; etely filled in by the		29a. Certifier 1½ Certifying (Check only 2 Medical Ex	Physician: To the best	of my knowledge	, death	occurred at the tim	e, date and place,	and due to the cau	use(s) and manner	as stated.
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	une)	aminer: On the basis of and manner sta	ted.	J/OI INV			eu at the time, dai	e and place, and d	ue to the cause(s)
	To To Com	≥	29b. Signature and title of certifier	1	11/1/)	29c. License	number	29	d. Date signed (Mo	nth, Day, Year)
1	1		> sur		1		D5868	1		3/22/05	
	12		30. Name and address of person wh				-				
			JUDE ALEXANDER,	M.D., 8600	OLD GEO	RGE	TWON RD.	, BETHESD	A, MD 20	815	
- 5	Star Registra	9	31. Date filed (Month, Day, Year) MAR 2 8	2005 Registra	ar's Signature	400	We .				

			1 - For State Registrar	State	of Maryla		artment of F rtificate of		and Men		jiene ()	05	12	192
	Physici	0 m	1. Decedent's Name (First, Middle,	Last)			-			ate of Deat		Year	3. Time	of Death
1	/Medic		Lillian B. Da	vis						arch 2		2005	7:30	Ам
	Examin	er	4a. Facility Name (If not institution,		mber)		4b. City, Town, o		of Death			y of Death		
			College View Cer 5. Social Security Number	iter .Sex	7 Ago (In uso	s. last birthday)	Frederi		24 Hrs 7 a D	-1		deri		
г	Funeral Director		244-38-2159	1 M 25 F	89	Yrs.	Months Days	Hours		ate of Birth Month, Day,	Year)	Cou	^{place} (State intry) th Car	
	ס		Usual Residence of Decedent							J. 1,	1710	NOI	tii cai	OTTHA
	anylar show	_	10a. State 10b. County			ity, Town or Lo							10d. Inside (•
	88a-f	Director	WVa Morga	n 	(Great Ca								s 2:03:No
	with ti		10e. Street and Number				10f. Zip Code				0g. Citizen of		-	
	ns 23	erai	388 Justin Lane	12 Was Dec	edent Ever in t	115 13 1	25422 Was Decedent of F	lienanio Orio	rin? (Spanify)		United		es can Indian,	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28e-f show any njury or other traumatic event, The Madical Eramfran must be notified at once.	Funerai	1 Never Married 2 Married	Armed Fo	orces? 2No		f Yes, specify Cub	an, Mexican	, Puerto Ricar	, etc.)	Bla	ick, White	etc.	
003	urel',	d by	3 XWidowed 4 ☐ Divorced	If Yes, Gr Year or D	ve Dates:		1 □ Yes 2 🖾 No	Specify:			Specia	fy: Whi	Lte	
15	"nat	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	lent's Usual Occup kind of work done DO NOT use retired	ation during most	of working		16b. Kind of B	Business/Ir	dustry	
12	withii ene. then	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Buto		<i>a)</i>			Winn-	Dixie	3	
b	filed Hyg other	Be C	17. Father's Name (First, Middle, La	st)				18. Mother	r's Name (Firs	t, Middle, N				
Maryland 21215-0036	uld be Menta Irked	To B	McIver M. Broo	oks				Loss	ie M. U	Jnknow	m			
lan	and and is ma		19a. Informant's Name/Relationship				g Address (Street				-		Code)	
ر ا	and lealth m 27 her tr		Robert Davis / S	on	1001	P.O.	Box 401,	Great						
סר	iges in of h		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3		State	cemetery, cren	sition (Name of natory or other plac	-	Date 3/24/20	105	20c. Location	•		
Baltimore,	it. Partmer rhant		4 □ Donation 5 □ Other (Spe21. Signature of Funeral Service Lice	••	Fr		Cremato:	ry ¦			Freder			
Ba	Depuring the control of the control		* Brodley &	mto		16	Name and Addre	umtown	Pike,	Fred	erick,	Home, MD 2	P.A. 1702	,
			23a. Part1. Enter the disease, or co shock, or heart ailure. List or	mylications that of lyone cause on e	aused the dea each line.	ith. Do not ente	er the mode of dyin	ig, such as o	cardiac or resp	oiratory arre	est,		Approxima Interval Be Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	5720								_	E go be _b
H	/Medical Examiner				(or as a conse		-					ò	0 Se	
		Je.	Sequentially list conditions, a y leading to in recitate cause. Enter Underlying Cause (Disease or injury		(or as a dunsa	CLENO	CIC CA	15 DI2	VASCO		SEASE		- A	711
	cuted nd ransit	Examiner	that initiated events	C							,,,,,			
, 0	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to	(or as a conse	quence of):								
8760,		dicai		d			-							
9 X	leath certific attending p	/Me	IF FEMALE:	23c. If yes, out	tcome of prean	ancv					201 0	A		
Вох	death a atter	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo	1☐Live b	ointh 2 ☐ Fet lant at time of	al death 3	Ectopic pregnancy Other (specify)	1				ite of delivi onth		Year
Ö.	that the death led by the atter detached for u	hysi	9 Unknown	9□ Unkn	own									
S,	The law requires that the death certificate has been signed by the attending is age 2 should be detached for use as	by P	Part II. Other significant conditions	contributing to d	eath but not re	sulting in the ur	iderlying cause giv	en in Part I.	2	3e. Did tob	acco use con	tribute to t	ne cause of	death?
ord	w requir been si should	ted								1 🗌 Ye	s 2 14 No	3 Prob	ably 4 🗌	Unknown
Vital Records,	has bo	Completed							2	4a. Was ar autopsy	y	prior to co	psy findings	available cause of
a E	icien: The l certificate ha rector, page								1	perform		death? 1 ☐ Yes	2 -NO	
<u> </u>		o Be	25. Was case referred to medical examiner?	Hospital:			Oth		of Death Che			_		
o	Physer this sral di	-	1 ☐ Yes 2 ₺ No 27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of	28c. Injun	v at	sing Home 5		nce 6 □Oth w injury occur		y)	
on	nding Phath. r: After the funeral	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat		th, Day Year)	Injury	Wor	k? Yes 2∐N	lo		. ,			
Division of	Hospitel or Attenc 24 hours after death Funerel Director: tely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place	of Injury - At h	nome, farm, stre	eet, factory, office		28f. Lo	ocation (Str	eet and Numb	er or Rura	l Route Nun	nber,
	itel or A			1					1		_			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical Ex	aminer: On the ba	best of my knoasis of examination stated.	owledge, death ation and/or inv	occurred at the tin estigation, in my o	ne, date and pinion, death	place, and du noccurred at t	ie to the ca he time, da	use(s) and ma te and place,	anner as si and due to	tated. the cause(s	s)
	To t To t	Σ	29b. Signature and title of certifier				29c. Licens			29	d. Date signe	d (Month,	Day, Year)	
	1-		A	tul	こり			-31	912		3/7	4 10	25	
	5		30. Name and address of person wh	1.000				. (100	~ .\		7	1710	
	Sta		31. Date filed (Month) (AR) Year)		egistrar's Sign		IN PINS	, rv	ED F	FLICH	MD		1 10 0	
**	Registr		man 2'9	2000		M A	model of							

				01 1 (14	1 -1/5	. (11 14 1			
			For State	State of Mary		ent of Health and	Mental Hygi	ene nns	12102
			Registrer		Certifica	ate of Death		g. No 0 0 0	12133
	Physici	an	1. Decedent's Name (First, Middle, La	A /	~ ~ *	. 1 .	2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Ailene	. Rebe	cca Di	CKer SON	March	24, 2005	2350 "
	Examin	er	4a. Facility Name (If not institution, gi	1	1 1 .	Sity, Town, or Location of Dee	th	4c. County of Death	1
				General H		Cambrid		Dorche	
	Funeral			Sex 7. Age (In 1 M 2 1 F	yrs. last birthday) If Un- Month	ider 1 Year If Under 24 Hrs hs Days Hours Min		Year) 9. Birthi	place (State or Foreign
	Director		216-38-8519 Usual Residence of Decedent		cd IIIs.		OCT. 26	,1942 Ma	ryland
	and		10a. State 10b. County	10	c. City, Town or Location				Od. Inside City Limits
0	Maryland -f show fied at	ō	MD Donal	00 100	Cambria	dap			1 ☑ Yes 2 ☐ No
7	28a-	Director	10e. Street and Number	ES PER		Zip Code	10	g. Citizen of What Cour	ntrv?
Ç	death with the ms 23a or 28a r.r.ust be noti		1001 Came	lia Cipi	clo	2/6/3		1154	•
9	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13. Was De	ecedent of Hispanic Origin? (: specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Americ	
ထ	after or ita	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		1/	rto Rican, etc.)	Black, White,	
<u> </u>	filed within 72 hours after Hygiene. other then "natural", or ita ant, the Medical Exemine	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 Li Yes	s 2 No Specify:		Specify 3/a	cK
2	72 h	Completed	15. Decedent's E (Specify only highest gi	iducation rade completed)	16a. Decedent's U	Isual Occupation work done during most of wo	orkina 1	6b. Kind of Business/In	dustry
2	ithin Ban May	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retired)		11 1	1
2	filed wi Hygien thar th		100		Nuk.		<u>e</u>	HOSPita	<u>a/</u>
2	be find of the other of the other of the other of the other other of the other of t	Be	17. Father's Name (First, Middle, Las	0 12 (- 1			me (First, Middle, M		,
$\frac{3}{5}$	should ind Men s marks umatic	은	James	Kian		Jeni			
Maryland 21215-0036	12 st h and 7 is n traun		19a. Informant's Name/Relationship			ress (Street and Number or F ASh Ford C		/ 1 =	10 20/-(13
	1 and Healt am 2 thar 1		20a. Methed of Disposition	ROINN				Oc. Location - City or To	wn State
و	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3		20b. Place of Disposition (Incometery, crematory)		10.1		, wii, claic
Baltimore,	t. Part rtant		`4 □Donation 5 □ Other (Spec					ambridg	e, M.D.
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is merked other than "natural; or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinet must be notified at once.		21. Signature of Funeral Service Lice	2/2	Hen	and Address of Facility RY FUWERO	1 Home,	P.A.	115 7/1/2
		-	222 Part Fotor the disease of cor	nolications that caused the	rug 5/1	Machinicati	IN St. C.	ambe doe	M.D. 21013 Approximate
			23a. Pm1. Enter the disease, or conshock, or heart failure. List only	- 1		/	ic or respiratory arre	st,	Interval Between Onset and Death
	Physician (1	Immediate Cause (Final disease or condition resulting in death)	a pulmi	onary ea	lema			1 day
	/Medical Examiner		1	Due to (or as a co	J. 1	tan-in	^		2 22 2 2 11/1
Ш		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Ma/19 Due to (or as a co		ipertension	7		months
	ted nsit	Examiner	Cause (Disease or injury	12404	,	ery disea	SP] :	3 months
	al-tra	xar	that initiated events resulting in death) Last	Due to (or as a co		9 27 328			111011113
200	icate be executed physician and s the burial-transit	calE	· ·	- d					
				<u> </u>					
X	death certificate attending phy of for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr				23d. Date of delive	
ŏ	d for	cla	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time					ery
	the y the sche	S			a or dearn 2 \(\triangle	c pregnancy (specify)		Month	ery Day Year
o.	- D (0	=	9 Unknown	9□ Unknown	e or death 5Other				*
s, P.O. Box	s that med b e deta	y Phy	9 ☐ Unknown Part II. Dther significant conditions	9□ Unknown contributing to death but no		(specify)	23e. Did tob		Day Year
rds, P.O.	quires that en signed b uld be deta	by	9 🗆 Unknown	9□ Unknown contributing to death but no		(specify)		Month	Day Year ne cause of death?
cords, P.O.	aw requires that the de s been signed by the a 2 should be detached	by	9 ☐ Unknown Part II. Dther significant conditions	9□ Unknown contributing to death but no		(specify)	1 ☐ Ye. 24a. Was an	Month acco use contribute to tl	Day Year ne cause of death? nably 4 □Unknown
Records, P.O.	fhe law requires that te has been signed b age 2 should be deta	by	9 ☐ Unknown Part II. Dther significant conditions	9□ Unknown contributing to death but no		(specify)	1 ☐ Ye. 24a. Was an autopsy perform	Month acco use contribute to the signature of the signat	Day Year ne cause of death? nably 4 □Unknown psy findings available mpletion of cause of
tal Records, P.O.	an: The law requires that tificate has been signed b lor, page 2 should be delic	Completed by	9 □ Unknown Part II. Dther significant conditions Dichels 25. Was case referred to medical	9□ Unknown contributing to death but no		g cause given in Part I.	1 Ye. 24a. Was an autopsy perform 1 Yes 2	Month acco use contribute to the second sec	Day Year ne cause of death? nably 4 □Unknown psy findings available mpletion of cause of
Vital Records, P.O.	ysician: The law requires that is certificate has been signed b director, page 2 should be delt	Be Completed by	9 □ Unknown Part II. Dther significant conditions Direfes	9□ Unknown contributing to death but no MCILI FUS	ot resulting in the underlyin	ng cause given in Part I. 26. Place of De	1 Ye. 24a. Was an autopsy perform 1 Yes 2 ath (Check only one	Month acco use contribute to the second sec	Day Year ne cause of death? nably 4 Unknown psy findings available mpletion of cause of 2 No
of Vital Records, P.O.	g Physician: The law requires that er this certificate has been signed b ieral director, page 2 should be deta	To Be Completed by	9 Unknown Part II. Dther significant conditions Diefes 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	9 Unknown contributing to death but not MCILIFULS Hospital: 1 Inpatient 28a. Date of Injury	ot resulting in the underlyin 2 **E***P/Outpatient 3 ** 28b. Time of	26. Place of De DOA Other: 4 Nursing	1 Ye. 24a. Was an autopsy perform 1 Yes 2 ath (Check only one	Month acco use contribute to the second sec	Day Year ne cause of death? nably 4 Unknown psy findings available mpletion of cause of 2 No
ion of Vital Records, P.O.	nding Physician: The law requires that ath. r: Atter this certificate has been signed b ie funeral director, page 2 should be deta	To Be Completed by	9 □ Unknown Part II. Dther significant conditions Direfes 25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	9 Unknown contributing to death but not MCILIFUS Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye.	ot resulting in the underlying the u	26. Place of De	1 ☐ Ye. 24a. Was an autopsy perform 1 ☐ Yes 2 ath (Check only one) Home 5 ☐ Reside	Month acco use contribute to the second sec	Day Year ne cause of death? nably 4 Unknown psy findings available mpletion of cause of 2 No
vision of Vital Records, P.O.	Attending Physician: The law requires that steders that and selections that this certificate has been signed be by the funeral director, page 2 should be detailed.	To Be Completed by	9 Unknown Part II. Dther significant conditions Directes 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigating 1 Suicide 6 Could not	9 Unknown contributing to death but not make the solution of	2 **EP/Outpatient 3 **Description of Injury Medical Athome, farm, street, fac.	26. Place of De 26. Nursing 28c. Injury at Work? 1 Yes 2 No	1 Ye. 24a. Was an autopsy perform 1 Yes 2 ath (Check only one) Home 5 Resider 28d. Describe how	Month acco use contribute to the second sec	Day Year ne cause of death? nably 4 □Unknown psy findings available mpletion of cause of 2 □ No
Division of Vital Records, P.O.	tal or Attending Physician: The law requires that is after death. Is after death. In it is certificate has been signed be in fector: After this certificate has been signed be divertor the funeral director. Page 2 should be detailed in by the funeral director.	To Be Completed by	9 Unknown Part II. Dther significant conditions Director 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigating suicede 6 Could not	9 Unknown contributing to death but not MCILI FUS Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye)	2 **EP/Outpatient 3 **Description of Injury Medical Athome, farm, street, fac.	26. Place of De 26. Nursing 28c. Injury at Work? 1 Yes 2 No	1 Ye. 24a. Was an autopsy perform 1 Yes 2 ath (Check only one Home 5 Resider 28d. Describe hore	Month acco use contribute to the second sec	Day Year ne cause of death? nably 4 □Unknown psy findings available mpletion of cause of 2 □ No
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			1 - For State Registrar	State of Ma	arytano			t of Hea e of De		Mental H	ygien Reg. N		
	Physici /Medic			REVA I	DAVIS					2. Date of D Month MARC	eath D	ay 2005	3. Time of beath 11:15A M
	Examir		4a. Facility Name (If not institution, give MANOR CARE POTO				4b. City,	Town, or Lo POTOM	cation of De	ath		c. County of D MONTGON	
	Funeral Director			7. Ag	e (In yrs. la 90	st birthday) Yrs.	If Under Months		Under 24 H Hours M		Dav. Year	⁽²⁾ 1915 1	Birthplace (State or Foreign Country) NEW YORK
	faryland show	ō	Usual Residence of Decedent 10a. State 10b. County	·		, Town or Lo							10d. Inside City Limits 1 Yes 2 □ No
	the A	rect	MARYLAND MONTGON 10e. Street and Number	IERY	PO	OTOMAC	10f. Zip	Code			100 C	itizen of What	
	3a or	Di	10714 POTOMAC TEN	NIS LANE			Tot. Elp	20854			-		TES OF AMERIC
9800	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show dical Exactinet must be rodiffed at	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates:	Ever in U.S		Was Deced f Yes, spec	ent of Hispa ify Cuban, M		(Specify Yes or Nerto Rican, etc.)			merican Indian, hite, etc.
21215-0036	등 교육	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5		16a. Deced (Give life. L	ient's Usua kind of wor DO NOT us	l Occupation k done durir e retired)	n ing most of w	vorking	16b. I	Kind of Busine	ss/Industry
		Сош		5+		ГЕАСНЕ	R SUP	ERVIS	OR		PUB	LIC EDU	JCATION
Maryland	ould be filed Mental Hyg arked othe atic event,	O	17. Father's Name (First, Middle, Last)					18.		ame (First, Middl			
7	should id Mer marke matic	5	LOUIS KAHN 19a. Informant's Name/Relationship (Ty	ne Print)		19h Mailin	a Address	(Street and		THA SCHO:			7:- Code)
Ma	nd 2 s lith an 27 is r trau		RICHARD M. DAVIS	,						EXINGTON			a, Zip Code)
Baltimore,	of Head		20a. Method of Disposition		20b. Pla	ace of Dispo: metery, cren	sition (Nam	e of her place)	Ī	Date	20c. L	ocation - City	or Town, State
ij	ment in in in in in in in in in in in in in		1 ☐ Burial 2 【Cremation 3 【F `4 ☐ Donation 5 ☐ Other (Specify)		1	IONAL	CREMA	TORY		23/2005			RCH, VIRGINIA
Ball	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or either traumatic evone.		21. Signature of Funeral Service Licens	Stottler	nuc	DA DA	. Name and NZANS 170 R	Address of KY GO	f Facility LDBERG	G MEMORIA	AL C	HAPEL,	INC.
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused ne cause on each lin	the death.	Do not ente	er the mode	of dying, s	uch as cardi	ac or respiratory	arrest,	trer y - Pitt	Approximate Interval Between
	Physician (Martina)	8	Immediate Cause (Final disease or condition resulting in death)	MULTIPL	Е МҮЕ	LOMA							Onset and Death 3 YEARS
	/Medical Examiner			Due to (or as a	a conseque	ence of):							
		ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a	a conseque	ence of):							
	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
60,	be ex ician burial	a E	resulting in deathly East	Due to (or as a	a conseque	ence of):							
68760,	ficate physis the	edicai									_		
.O. Box	death cert e attendin d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal o	death 3 🗌	Ectopic pre Other (spe					23d. Date of d Month	leliv <i>e</i> ry Day Year
Δ.	ng ja	by	Part II. Other significant conditions cor	tributing to death bu	it not result	ting in the un	derlying ca	use given in	Part I.				to the cause of death?
Vital Records,	has beer ge 2 shou	Completed						-		24a. Was	psy	prior to	autopsy findings available completion of cause of
a			25. Was case referred to medical							1 ☐ Yes		death'	s 2 No
	Physicien: this certific ral director,	To Be	examiner?	lospital:	nt 2□E	R/Outpatient	3□ 004	O41		eath (Check only Home 5 Res		6 DOthor (Se	aggiful
Division of	문 유 le		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 2	28b. Time of Injury		c. Injury at Work?	2 □ No	28d. Describe			веспу)
Divisi	or Atter after dea Director in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At horr . (Specify)	ne, farm, stre	et, factory,			28f. Location (City or To	Street ar wn, State	nd Number or i e)	Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemir	ier: On the basis of	examinatio	ledge, death on and/or inv	occurred a	t the time, d	date and place	ce, and due to the curred at the time,	cause(s) and manner a	as stated. ue to the cause(s)
	ro the within to the comple	Mec	29b. Signature and title of certifier	and manner stat			29c.	License nui	mber		29d. Da	ite signed (Moi	nth, Day, Year)
)	18		AlNothan				D	00536	15		MAR	CH 22,	2005
			30. Name and address of person who co ARUNA NATHAN, M.D.			23a) (Type, F	Print)			ROCKVILL			
	Sta Registra	_	31. Date filed (Month, Day, Year) MAR 2 5 2005	Registra				_, " <i>L</i>	, 1		-, II	2000	

			For State Registrar		State of	f Maryla	nd / Dep <i>Ce</i>	artmen <i>rtificat</i>				ental Hy	/gien Reg. N	4000	121	95
	Physic /Medi		Decedent's Nam Rich		e, Last) lark Eising	ner.					2	2. Date of D Month Manch	Da			Death A
7	Examir			If not institution	n, give street and nun		1 Cente			Location o		ITTEON		c. County of De	ath	
	Funeral Director		5. Social Security N 212-30-02 Usual Residence of	73			s. last birthday, Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	Date of Bi (Month, D			irthplace (State of Country)	or Foreign
	Maryland f show	or	10a. State	10b. County			City, Town or Le								10d. Inside C	•
	th the h	Director	10e. Street and Nu					10f. Zip	Code				10g. C	itizen of What (
	ath wil	ralD	3706 Ser	ninole						21863			US			
5-0036	772 hours after death with the Maryland "natural", or Itams 23a or 28a-f show odical Examiner must be inclined at	by Funeral	11. Marital Status1 ☐ Never Marr3 ☐ Widowed		12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da		U.S. 13.	Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		fy Yes or No can, etc.)	0-	14. Race - An Black, Wh Specify: Wh	ite, etc.	
5-0	72 ho	eted	(Spec	15. Deceden	it's Education st grade completed)		16a. Dece	dent's Usua kind of wo	I Occupa	ition Jurina mos	t of working	,	16b. F	Kind of Busines	s/Industry	
2121	ges 1 and 2 should be filed within 72 hc 1 of Health and Mental Hygiene. If item 27 is marked othar then "natun or other traumatic event, If a Madical	Completed	Elementary/Seco	ondary (0-12)	College (1	-4or 5+)		_{DO NOT us} Iwrig)	t of working		Sta	inless	Steel	
Maryland	2 should be filed withir and Mental Hygiene. is markad othar than surmatic avent, It e M.	To Be (17. Father's Name Paul Rol		,							First, Middle		n Sumame)		
ary	shou and M s mar	-	19a. Informant's N				19b. Maili	ng Address	(Street a					or Town, State,	Zip Code)	
	ges 1 and 2 t of Health If itam 27 i or other tre		Lois M.		er	201				Dr.				ld. 2186		
Baltimore,	Pa Int		20a. Method of Dis 1 Burial 2 4 □ Donation	Cremation	3 □Removal from Specify)	21.010	Place of Dispo cemetery, cre kemie	matory`or o.	ther place	em . 3	Dat 3-30-0			ocation - City o		
Balt	permit. Pag Department Important: I any injury o		21. Signature of Fu	meral service	Licensee									Funera , Md.	1 Home 21863	
			23a. Part1. Enter 1 shock, or hea	he disease, o it failure. List	complications that of	used the dea									Approximate Interval Bets	ween
	Pnysician /Medical		Immediate Cause disease or condition resulting in death)	(Final on		isna.	7.1	Meso	thei	lion	9				3 mon	
	Examiner				Due to (or as a conse	equence of):									
	ted sit	Examiner	Sequentially list co if any, leading to in Cause (Disease or	nditions, nmediate rhying injury	b. Due to (or as a conse	equence of):									
,00	be executed sician and burial-transit		that initiated events resulting in death)	6	c. Due to (d	or as a conse	equence of):									
68760	icate be ex physician s the buria	dlcal			d			<u> </u>								
O. Box	that the death certificate be executed by the attending physician and detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2[9 Unknown	months? ☐ No		nth 2 ☐ Fet ant at time of	tal death 3 [Ectopic pro						23d. Date of de Month		'ear
ords, P	signe d be	by	Part II. Other signif	icant condition	ons contributing to de	ath but not re	sulting in the u	nderlying ca	use giver	n in Part I.		23e. Did t			to the cause of detrobably 4 \(\subseteq 0	
Vital Records,		Completed											an psy ormed? 2 \(No	prior to death?	utopsy findings a completion of ca	available ause of
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case reference examiner?		Hospital:							Check onl				
on of		-	1 ☐ Yes 2 ☐ 27. Manner of Deat 1 ☐ Natural 2 ☐ Accident		g 28a. Date o		28b. Time of Injury		3c. Injury Work	at	280	5 🗌 Resi		6 □Other (Spery occurred	ecify)	
Division	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune	Certification	3 Suicide 4 Homicide	6 Could determ	not be 28e. Place	of Injury - At I g, etc. (Spec	home, farm, str ify)	eet, factory				Location (ural Route Numb	ber,
	To the Hospital within 24 hours a To the Funaral I completely filled	edical C	29a. Certifier (Check only one)	1 Certifyin 2 Medical	g Physicien: To the Examiner: On the ba and mann	sis of examin	nowledge, death nation and/or in	occurred a vestigation,	it the time in my opi	e, date and nion, deat	d place, and h occurred	due to the at the time,	cause(s date and) and manner a d place, and du	s stated. e to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and	title of certifie	1/ -	m	.0.	1	License					te signed (Mon		
			17	16					レゴ	069	O		Mas	rch 27	2005	-
1	+. 10+1		30. Name a addr	ess of person	o completed cause	of death (Ite	m 23a) (Type,	Print)	1001	15	γ.	Salie	500	~~ N	15 213	80.
	Sta Registr		31. Date filed (Mon	th, Day, Year)	8 2005 32.80	gistrar's Sign	nature	radi				/ - 2			2 210	

			State of Maryland / De State of Maryland / De Registra MEND#23a(a/b)perMD3/28/05, EMW, MeCo C			ne 005 2196
ı	Physic		Decedent's Name (First, Middle, Last) SEYMOUR	ETKIN	2. Date of Death Month March	Day Year 3. Time of Death 20, 2005 11:15 AM
	/Medi Examir		4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Location of Dea		4c. County of Doath Prince George's
	Funeral Director		5. Social Security Number 102–03–4623	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9 Birtholage (State or Foreign
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Prince George's Adelphi			10d. Inside City Limits 1 ☐ Yes 2X No
	h with the	Funeral Director	10e. Street and Number 3210 Powder Mill Road, #140	10f. Zip Code 20783	1	. Citizen of What Country? United States
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "neturel", or Items 23e or 28e-1 show enty Injury or other treumatic event; Item Medical Ever's part, was be nutified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Sive Sive Year or Dates: 945 – 1946	3. Was Decedent of Hispanic Origin? (; If Yes, specify Cuban, Mexican, Puer 1 Yes No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 ho lene. r then "natur I'e Medical	Completed	(Specify only highest grade completed) (Gi	pedent's Usual Occupation ve kind of work done during most of wo . DO NOT use retired) tistician	rking	b. Kind of Business/Industry ederal Government
Maryland 2	d 2 should be filed within ? h and Mental Hygiene. 7 is marked other then "r treumatic event, the Med	To Be C	17. Father's Name (First, Middle, Last) Harry Etkin	18. Mother's Na Lena	me (First, Middle, Mai	
	ss 1 and 2 shoi of Health and N iltem 27 is ma Lothar treuma			iling Address (Street and Number or A Cadbury Drive Ode		
Baltimore,	permit. Pages 1 a Department of He Importent: If Item eny Injury or oth		cemetery, ci	position (Name of ematory or other place) litan Crematory 3,		c. Location - City or Town, State Alexandria, Virginia
Balt	permit. Departr Importe eny Inji		Nonall 1.10 organis	Sonald Vir Borgward 4400 Powder Mill F	coad Beltsi	ville, Maryland20705
8760,	physician and the burial-fransit in burial-fransit	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Tau W. A. Paramini	c or respiratory arrest,	Approximate Interval Between Onset and Death
.O. Box 687	The law requires that the death certificate ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Medic		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that baan signad b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death? 2 No 3 Probably 4/10Unknown
il Records,	: The law requ cate has baen , page 2 shoul	Completed			24a. Was an autopsy performed	
ion of Vital	nding Physician: Thath. ath. r: After this certificate e funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes	ent 3 DOA Other: 4 Nursing F	ath (Check only one) the thick only one) the thick only one of the thick only one of the thick only one one of the thick only one of the thick one of	e 6 ⊡Other (<i>Specify</i>) njury occurred
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	he Hospii in 24 hour he Funer pletely fills	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, detailed the best of my knowledge the best of my knowle	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	10 com	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
_	10		30. Name and address of person who completed cause of death (Item 23a) (Type Joseph M. Layu q M.D. 14201 Lau	erel Park Drive, Si	uite 111	Laurel, MD 20707
	Sta Registr	_	31. Date filed (Morth, Day, Year) 32 registrar's Signature	arte		,

			1 - For Stete Registrar		State of M	1arylan			t of H	lealth a	and M			000	5	12	197
	Physic	an	Decedent's Name (Fire		,							2. Date of De Month	ath Da	y Ye		3. Time of	Death
	/Medi	cal		Alfred	Ellis			45 03. 3	F	1 1	10.00	March 2		2005		5:00	ам
	Examir	ner	4a. Facility Name (if not i	_						Location			40	County of D			
	Funeral	-	5. Social Security Number	ersity 6.S			ast birthday,	If Under	1 Year	Sprin If Under	24 Hrs.	8. Date of Bir (Month, Da	th	Montg 9	Omer Birthplac	y e (State or	r Foreian
П	Director		524-30-8379)	DXM 2□F	74	Yrs.	Months	Days	Hours	Min.	(Month, Da Oct.23	y, Year, 193		Country 1ora	ido	
	and		Usual Residence of Dece 10a. State 10b.	. County		10c City	, Town or L	ocation								. Inside Cit	. I taka
	Maryl f sho	to													100.	1 ☐ Yes	•
	r 28a	Director	Maryland Mo 10e. Street and Number	ontgome	ery	51	lver	Spring 10f. Zip					10g. Ci	tizen of What	Country	?	
	23e o		1502 Unive	ersity	Boulevar	l. Wes	: †			20902	•			USA			
	Items	Funeral	11. Marital Status	•	 Was Deceden Armed Forces 	t Ever in U.: ?	S. 13.	Was Decede				cify Yes or No Rican, etc.)	-	14. Race - A Black, W			
36	rs afte	by F	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ □	_	1 ☑ Yes 2 ☐ If Yes, Give Year or Dates] No		1 ☐ Yes 2		Specify:				Specify:	, , , , ,		
9	72 hours after death with the Maryland "neturel", or Items 23e or 28a-f show salical Extractivest by rutified at	ted	15. [Decedent's Ed	lucation	Kor	16a. Dece	dent's Usual	Occupa	ation			16b. K	(ind of Busine	Whi ss/Indus		
218	5 24	Completed	(Specify on Elementary/Secondary		de completed) College (1-4or	5+)	(Give	kind of work DO NOT use	k done d e retired	turing mos ')	t of workii	ng				,	
121	filed with Hygiene. other the		12	14:14:1			Barb	er						sonal	Care		
and	t be find the other of the other constructions and other constructions are not the other constructions and the other constructions are not the other construct	o Be	17. Father's Name (First,							18. Mothe	er's Name	(First, Middle,	Maider	n Sumame)			
Maryland 21215-0036	should nd Me mark matic	ĭ	Russell Jac 19a. Informant's Name/F				19b. Maili	ng Address	(Street a			l Dean <i>I Route Numb</i> e	er City	or Town State	e Zin Co	ode)	
Baltimore, Ma	permit. Pages 1 and 2 should be filed Department of Health and Mental Hygid Important: If item 27 Is marked other any nijury or gither treumatic event. If once.		Effie M. E1 20a. Method of Dispositio 1 ☑ Burial 2 ☐ Cre '4 ☐ Donation 5 ☐ 0 21. Signature of Funeral	Llis on emation 3 [Other (Specify	Wif Removal from State	20b. Pl	1502 ace of Dispo emetery, crea klawn	Unive	e of her place ial ark Addres J.	by B1 M s of Facilit Coll	vd., ar.2	West 6,2005 Funeral	Silv 20c. L Rocl	ver Sp: ocation City kville	ring or Town	MD 2 State	
			23a. Part. Enter the dis	ease or come	Nications that cause	od the death	159	JO Uni	ver	sitv.	Blvd	WSi	lve:	r Śpri	ng,M		
	Physician /Medical	85.75	23a. Parm. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	re. List only	aDiffus	e Lar	ge B-0				cardiac o	r respiratory ar	rest,		Int Or	proximate terval Betw nset and Do Year	eath
	Examiner				Due to (or as	s a consequ	ence of):										
,0,	cate be executed by sician and the burial-transit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ns,	c. Due to (or as												
8760,	icate b physic s the b	dlca			d												
.O. Box 6	death certif e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent preging the past 12 month 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	nant	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pre						23d. Date of o	delivery Day	y Ye	9ar
<u>α</u>	The law requires that the ste has been signed by th page 2 should be detache	by	Part II. Other significant	conditions co	ontributing to death I	but not resul	Iting in the u	nderlying car	use give	n in Part I.			es 2	use contribute ☑No 3□		ause of dea	
Vital Records,		Completed							<u>-</u>			24a. Was autop perfor 1 Yes	sy med?	death	o comple	etion of cau	/ailable use of
Vita	Physicien: Th this certificate ral director, pac	Be	25. Was case referred to examiner?	i	Hospital:				Otho	-		(Check only o			- 0 -		
oţ	Phys r this aral dii	. To	1 Yes 2 No		1 ☐ Inpati		R/Outpatier 28b. Time of	t 3 DOA		4 🗆 1401		e 5 🙀 Resid 8d. Describe h			pecify)		
lon	Attending I r death. actor; After by the funer	atlor	1 XNatural 5 ☐ 2 ☐ Accident	Pending investigation	(Month, Da	ay Year)	Injury	м	c. Injury Work 1 🔲 Y	? 'es 2 □ N		od. Bosonborn	Ow injui	y occurred			
Division	i grape	Certification:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of in	jury - At hor tc. (Specify)	me, farm, str	eet, factory,	office		2	8f. Location (S City or Tow			Rural Ro	oute Numbe	er,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	one)	redicel Exam	vsicien: To the best iner: On the basis of and manner st	of examination	rledge, death on and/or inv	occurred at estigation, in	t the time	e, date and inion, deat	d place, a	nd due to the o	ause(s)	and manner I place, and d	as stated ue to the	d. cause(s)	
	To the within To the comple	Σ	29b. Signature and title of	certifier	0	۱۸ -	^	29c.	License	number		12	29d. Dat	te signed (Mo	nth, Day	, Year)	
Í	140		0.40	100%	snand	, M.			3348	32		M	arcl	n 25, 2	2005		
1			30. Name and address of	_						Core		. V	1.	1 0077	7.0		
;·	Sta Registr		Sajeev Ana 31. Date filed (Month, Day		Regist	rar's Signatu	ne	rarkw Ø	ay	Gree	npelt	, Mary	Land	1 2075	/ 0		

State of Maryland / Department of Health and Mental Hygiene

			,	Certificate of Dea	ath	Reg. No. 005	12198
-		1. Decedent's Name (First, Middle,	Lest)		2. Dete of D Month		3. Time of Death
	Physician	MARGARET EL	IZABETH FIELD	S	MARCH	1 ^D 9, 2005	7:05 AM
	/Medical Examiner	4a Facility Name (If not institution,	nive street end number)	4b. Ci	ity, Town, or Location of Dea	th 4c. County of De	eath
1	Examine	DEVLIN MANOR N	URSING HOME	C	UMBERLAND	ALLEG	ANY
	Funeral		Sex 7. Age (In yrs. last	birthday) If Under 1 Year If L	Under 24 Hrs. 8 Date of B	irth 9. f	Birthplace (State or Foreign Country)
	Director	186-18-0675	1□ M ¾□ F 82	Yrs. Months Days Ho	ours Min. (Month, L AUG.	7, 1922 PE	NNSYLVANIA
		Usual Residence of Decedent					
	ylan how	10a. State 10b. County		own or Location			10d. Inside City Limits
	a-fs	MD ALLEC	SANY CUMI	BERLAND			My Yes 2 No
	vith the Mar or 28a-fs be notified Director	10e. Street end Number		10f. Zip Code		10g. Citizen of What	Country?
	h wi	824 SHRIVER AVE	NUE	21502		U.S.A.	
	uffar death v r items 23e other must. Funeral	11, Marital Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of Hispan If Yes, specify Cuban, Mo	nic Origin? (Specify Yes or Nexican, Puerto Rican, etc.)	Io- 14. Race - Ai Black, W	merican Indian,
020	by	1 ☐ Never Married 2 ☐ Married 3 🖔 Widowed 4 ☐ Divorced		1 ☐ Yes X ☐ No Sp			WHITE
21215-0020	ed within 72 hor ygiene. For than "natura it, the Medical I	15. Decedent's (Specify only highest		Se. Decedent's Usuel Occupation (Give kind of work done during life. DO NOT use retired)	g most of working	16b. Kind of Busine	ss/Industry
12	within then then mp	Elementary/Secondary (0-12)	College (1-4or 5+)	SALES CLERK		RETAIL	STORE
2	Hygied Hygied of Co	17. Father's Name (First, Middle, La	st)		Mother's Name (First, Middle		DIOILE
ano	ntal H	JAMES MCNULTY	,		ELIZABETH	(UNKNOWN)	
2	2 should be filed within and Mantal Hygiene. Is marked other than reumatic event, the M	19a. Informant's Name/Relationship	(Type Print) 1	9b. Mailing Address (Street and I			e. Zin Code)
Ma	d 2 s th an 7 is i	ROBERT L. FIELI		12825 ELLERSLIE			21502
a,	1 and Haaith am 27 ither tr	20a. Method of Disposition	20b. Place	of Disposition (Name of	Date	20c. Location - City	
Baltimore, Maryland	S = = >	1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Hemoval from State	ntery, crematory or other place) LAWN MEML • GARDE	NS 03/22/200	5 LAVALE	, MD
Sall	parmit. F Departme Importan eny injur once.	21. Signature of Funeral Service Lic	ensee	22. Name and Address of UPCHURCH FI	Facility NERAL HOME, I	P. A.	
ш	20599	(Thoras I)	Lochence)		STREET, CUME		21502
		23a. Part1. Enter the disease, or co	mplications that caused the death. D	o not enter the mode of dying, su	uch as cardiac or respiratory	arrest,	Approximate Interval Between
	Physician	Shook, or hour, railare. Else or	y one sauce on saur me				Onset and Death
	/iviedical	Immediate Cause (Final disease or condition	P	1 to l			15 canys
	Examiner	resulting in death)	a. Due to (or as	a consequence of):			
	ne .						
	The law raquires that the death certificate be assecuted ate has been signed by the attending physician and paga 2 should be datached for use as the burial-transit completed by Physician/Medical Examiner	Sequentially list conditions,	Due to (or as	a consequence of):			
Ö,	a axe ian a urial-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					1
68760,	e as the bur	that initiated events resulting in death) Last	Due to (or as	e consequence of):			
99 x	ing planting						
Box	eath ce attendi I for use		0				
	at the death or at the attend at a the strend at a the strend of the us	Part II. Other eignificent conditions	contributing to death but not resulting	g in the underlying ceuse given in	Part I. 23b. Die	tobacco use contrib	ute to the ceuse of death?
P.0	that the de led by the a datached i	(i) A	ceta. il.		10	Yes 2⊡No 3□	Probably 4 Unknown
	as tha igned be dat	- actioned	altyping De				
Records,	Tha law raquira pate has been sig paga 2 should to					s en autopsy 24 formed?	b. Were autopsy findings available prior to
ပ္ထ	aw range as be 2 sh						completion of cause of death?
ď	Tha law sate has paga 2				10	Yee 3 INO	1 ☐ Yes 2 ☐ No
Vital		25. Was case referred to medical		26.	. Place of Death (Check only	one	
>	nysician: nis cartifical director, To Be (examiner?	Hospital: 1 Inpatient 2 ER/	Outpatient 3 DOA Other: 4	Nursing Home 5 ☐ Re	sidence 6 Other (S	pecify)
10	E E .	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28t	o. Time of 28c. Injury at Work?	28d. Describe	how injury occurred	
<u>o</u>	ath. :: Aftr a fur	1 Natural 5 Pending 2 Accident investiga		M 1 ☐ Yes	2 🗆 No		
Division	or Attanding Is after death. Director: After I in by the funer	3 Suicide 6 Could no 4 Homicide determin	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location	(Street end Number or own, State)	Rural Route Number,
Ö	tal or Attanding P rs aftar death. at Director: Aftar t led in by the funers Certification:		building our (opposity)		,		
		29a Certifler 1 Certifying (Check only 2 Medical Ex	Physician: To the best of my knowled aminer: On the basis of examination	lge death conumed at the time di	ate and place, and due to the	date and place, and	as stated.
	he Hospi in 24 hou he Funar plataly fil edical	one)	and manner stated.	under investigation, in my opinior	in, death occurred at the time		
	To the within to the common to	29b. Signature and title of certifier	11	29c. License nur		29d. Date signed (Md	
	5		elmo ha	D001	7565	man 21, 0	Hev 3
	_	30. Name and address of person wh	o completed cause of death (Item 23				
	nos	AJTAIL ins M	D FLL NET!	Hung L2 V214	c 17 31	502	
	State	31. Date filed (Marrin Day, Mean	D 511 Not 1 2005 32 Registrar's Signature	Someth.			
	Registrar		TOOD James No.	The state of the s			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Marylai	Certificate		R	leg. No 200	5	219
Physician	Decedent's Nama (First, Middle, Last				2. Data of Dea Month	Day Y	'ear	ime of Death
/Medical	Harold 4a Facility Nama (If not institution, give	Leslie	Fields,		March 16,			145 PM
/ Examiner			la sa da man		Location of Death	4c. County of		
	Allegany County Nu 5. Social Security Number 6. Sa			Cumberl aar If Undar 24 Hrs			legany	
Funeral Director		ÑM 2□F 81		ays Hours Min			Country) Pennsylva	State or Foreig ania
fand	10a. State 10b. County	10c. C	ity, Town or Locetion				10d. Ins	ida City Limits
Man Freh for	MD Allegany		Cumberland				10]Yas 2∭ N
th with the 23a or 28a	10e. Street and Number 11305 Sunrise Av	enue, N.E.	10f. Zip Co	da 21502	1	0g. Citizen of What	at Country?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exarciner must be notified at page. To Be Completed by Funeral Director	11. Marital Status 1 □ Naver Marriad 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Dacadant Evar in U Armed Forcas? 1 ☑ Yas 2 ☐ No 194 If Yes, Giva Yaar or Datas: 16	1.3	of Hispanic Origin? (Cuban, Mexican, Puar No <i>Specify:</i>	Spacify Yas or No- to Rican, atc.)		Amarican Ind Whita, etc.	ian,
2 hor 2 hor	15. Decedant's Edu	cetion		ccupation		16b. Kind of Busin	White nass/Industry	**-**
within 7 ene. than "n. hed	(Specify only highest grad	e completed) College (1-4or 5+)	16e. Decedent's Usual O (Give kind of work d life. DO NOT use n		orking		ĺ	
Hyging Hyging Shering	17. Father's Nama (First, Middle, Last)	PAGE .	Dairy Departme		me (First, Middle, I	Supermari Maiden Sumame)	ket	
Mental H Mental H srked oth srtic even	Harold 1	eslie	Fields, Sr.	Louisa	Ma	v	Winebre	nner
nd M nd M nmer	19a. Informant's Name/Relationship (T)		19b. Mailing Address (St			, , , , , , , , , , , , , , , , , , , ,		
nd 2 aith a 27 is r train	Ruth Fields / wife		11305 Sunris					
f Hear f Hear ftern othe	20a. Method of Disposition	20b. í	Place of Disposition (Name of Commetery, crematory or other		7	20c. Location - Cit		
Page ent o nt: Iff I	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	ieniovai ironi State	Veterans' Cemete	l l	an 03/21/0	nos Flinta	stone M	D
artmoortan Injur	21. Signature of Funaral Service Licens			drass of Facility A				
Dep Imp	23a. Part 1. Enter tha disaase, or compl	Elome	404 Dec	atur Street,	Cumberland	d, MD 2150		
Physician /Medical Examiner	Immediata Ceuse (Final disaasa or condition resulting in death)	Loven Dua to (c	or as a donsequance of):	y Dige	and		/0	Yv S
rificate be executed to physician and as the burial-transit	Sequentially list conditions, if any, leading to immadiate causa. Enter Undarlying Cause (Disease or injury that initiated events rasulting in death) Last		or as a consequence of):					
nat tha death certific d by the attending p latached for use as Physician/Mee	L.	l						
deat ne att ed for	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying cause	givan in Pert I.	23b. Did to	bacco usa contri	buta to tha ca	use of deati
as that tha death cer igned by the attendir be datached for use by Physician/A	Dementa				1 □ Ye	2□ No 3	Probably	4 🗆 Unkno
been s should					24a. Was ar parlom		4b. Were auto available p complation of death?	
The law te has bage 2 age 2 compl					1 □ Ye	s 2ENo	1 □ Yas	2 No
artifica actor, p	25. Was cese refarred to medical			26. Place of Das	ath (Check only one			
Physician: this cartific ral diractor,	axaminer? 1 ☐ Yas 2 ☐ No	ospital:	ER/Outpatient 3□ DOA	Aut A	iome 5□Rasida		Specify)	
ding Phy th. After thi funeral	27. Mannar of Death 1. Neturel 5 ☐ Pending 2 ☐ Accident invastigation	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. I	njury at Work? I □ Yas 2 □ No	28d. Describe ho		эрвану)	
To the Neptral or Attending Physician: The is within 24 hours after death, To the Funeral Director: After this cartificate ha completaly filled in by the funeral director, page Medical Certification: To Be Com	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicide datermined	28a. Place of Injury - At he building, etc. (Specif	oma, farm, straet, factory, off		28f. Location (Str. City or Town,	eet and Number o , State)	or Rural Route	Number,
within 24 hours a To the Funeral D completaly filled i	29a. Certifier (Check only one) 1 Certifying Phys	iclan: To the best of my kno- er: On the basis of examinal and manner stated.	wledge, death occurred at th tion and/or investigation, in n	time, date and place by opinion, death occu	, and due to the ca rred at the time, da	use(s) and manne ite and place, and	er as stated. due to the car	use(s)
vithii vi	29b. Signature and title of certifier	1. /	29c. Lic	ense number	. A	d. Date signed (N		
SlivA	1	m a	170	033280	1	March	17 200	95
JIVA	30. Nama and address of person who con	nplatad causa of deeth (Item		· //-1-	1		,	
nas	0 11 7 0		Kent Avenue, Cu	mberland Ma	nvland 215	502		
State Registrar	31. Data filed (Month, Day, Year)	32 Ragistrar's Signa	tura Angella	TIA TIA	-yaculu Zl	W.L.		

			1 - For State Registrar		partment of Health and Nertificate of Death		ene 005	12200
	Physici		1. Decedent's Name (First, Middle, Last,	SEN FOSTER		2. Date of Death Month MARCH		3. Time of Death
	/Medic Examin Funeral Director		4a. Fecility Name (If not institution, give CITIZENS NUM. 5. Social Security Number 6. Sec	street and number) 25(NG NomE	Months Days Hours Min	8. Date of Birth (Month, Day, Y	4c. County of Death MEDERIC	
	ith the Maryland or 28a-1 show	Director	Usual Residence of Decedent 10a. State 10b. County AL. AEDC 10e. Street and Number		1 Location OFR (CLL 10f. Zip Code	100		Od. Inside City Limits 1 ☑ Yes 2 ☐ No
5-0036	d within 72 hours after death with the Maryland Jione. I than "natural", or Itams 23a or 28a-1 show Itan Wedisal Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: BL	
2121	d within 72 giene. or than "nat	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed) (G.	recedent's Usual Occupation vive kind of work done during most of work e. DO NOT use retired) DON-ESTIC	Ing A	Bb. Kind of Business/Ind	-
Maryland	ould be file Mental Hyg larked othe	To Be	EdWARD AL	STON	HELEN	e (First, Middle, Ma		
altimore, Mar	permit. Pages 1 and 2 should Department of Health and Mer Important: If Itam 27 is marke any injury or other traumatic once.		19a Informant's Name/Relationship (Ty PAYFIEL TO ST 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service pacense	temoval from State 20b. Place of Discemetery, of FATAVI6	rematory or other place)	PAY FREY 20 4 30, 2005	D. MD. 21 DC. Location - City or Tov - FREDERIC	Mr. State
8760,	Physician by Secured Medical Examiner the purial transit	dicai Examiner	23a. Part I. Entact Me disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death. Do not a	MOW. South ST. enter the mode of dying, such as cardiac which is a such as cardiac. when it is a such as cardiac.		t,	Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certifics tie has been signed by the attending proage 2 should be detached for use as it	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{W} \) No 9 \(\text{Unknown} \)		3 ⊟Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery	y Day Year
۵.	w requires that t been signed by should be detac	þ	Part II. Other significant conditions con	tributing to death but not resulting in the	o underlying cause given in Part I.	T .	cco use contribute to the	cause of death?
al Records,		Completed				24a. Was an autopsy performer	d? death?	sy findings available pletion of cause of
Division of Vital	ding Phya I. After this funeral di	ation: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 tnpatient 2 EP/Outpati 28a. Date of Injury (Month, Day Year) 28b. Time tnjury	ient 3 DOA Other: 4 Nursing Ho	me 5 ☐ Residenc 28d. Describe how	ee 6 ⊡Other (Specify) injury occurred	1000
Divis	tal or Attendest s after death al Director: ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural i State)	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 14 Certifying Phys 2 Medical Examin	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the caus ed at the time, date	se(s) and manner as state and place, and due to the	ed. he cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Kaufmin	29c. License number		Date signed (Month, Da	*
	14		30. Name and iddress of person who cold	meter cause death (Item 23a) (Type FMANN 300 W		DEBILL	m/ 21	701
	Sta Registra		31. Date filed (Month Per Year) 9 20	32. Vigistrar's Signature	fred	verily ,	11112 011	

	ian	Decedent's Name (First, Middle,	•				2. Date of Death Month	g. No. CUU	3. Time of Death
_/Medi	cal	Kenneth Way 4a. Facility Name (If not institution, c			O'1 - T			24,2005	9:20p M
Exami	ner	Union Hos	,	41	Elkto:		(n	4c. County of De	
Funeral			Sex 7. Age (In yrs.		Under 1 Year onths Days	If Under 24 Hrs Hours Min		Ceci 9. Bi	rthplace (State or Foreign
Director		221-38-0908 Usual Residence of Decedent	½ M 2□ F 53	Yrs.	Official Days			28,195	1 KTY
land ow		10a. State 10b. County	10c. C	ity, Town or Locati	on				10d. Inside City Limits
h the Marylan r 28a-f show notified at	ctor	MD Cec	i 1	E1kton					1 ☐Xes 2 ☐ No
death with the Maryland ms 23e or 28a-f show Imust be notified at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
s 23e		300 Abbott			219			J.S.A.	
e = =	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 XNo	J.S. 13. Was	Decedent of His s, specify Cuban	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
hours af turel', or at Exam	þ	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates:	1 🗆	Yes 2√ No	Specify:		Specify: W	hite
72 hc	Completed	15. Decedent's (Specify only highest of	Education trade completed)	(Give kind	's Usual Occupat d of work done du	uring most of wa	rkina 1	6b. Kind of Business	s/Industry
d within piene. r than	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retired)	3		Mary1an	d State
Hyg the int.	e Co	17. Father's Name (First, Middle, La		Labo	rer	18. Mother's Na	me (First, Middle, M		ommission
± 5 €	To Be	Harold V	Vayne Fleenoi	r			neva Hol		
d 2 should th and Mer 7 Is marke treumatic		19a. Informant's Name/Relationship			ddress (Street ar			City or Town, State,	Zip Code)
f Health item 27 other tr		Geneva Milott				Road,		rce, FL	34981
ges 1 If of H or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Content of the Content	Commence State	Place of Dispositio cemetery, cremato	ry or other place	Mar	ah 20	Oc. Location - City of	
nit. Pa artmer ortent: injury e.		* 4 Donation 5 ☐ Other (Special Signature of Fugeral Service Lice		nite Ci		etery	2005	Ft. Pie	rce, FL
permit. Departr Importe any inju		15-1	2/1/1/	And	me and Address	Gee 1	Funeral	Home	
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mulications that caused the deal	th. Do not enter th	9 East	Main such as cardia	St., Elk	ton, MD	21 0 2 1 roximate
Pnysician Pnysician		Immediate Cause (Final disease or condition	A						Interval Between Onset and Death
/Medical		resulting in death)	Due to (or as a consec		VCEPHAL	CHTHY			TDAILS
Examiner		Sequentially list conditions,		MATORY	falcol	2			TDAYS
led isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	, ,			1	1.	
be executed iclan and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	1,000,00	AC EFF	UNION	- AM	MINER	Www.
cate be exphysician the buria	dicai I		d				ROVED BY MEDICAL E	XAMII	
as		IF FEMALE:				RTIFICHT ON APP	ROVE		
ed by the attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Opic pregnancy	RIII		23d. Date of de	
0 0	ysic	1 Yes 2 No	4□Pregnant at time of d 9□Unknown	leath 5 ☐ Oth	ner (specify)			Month	Day Year
ed by detac	Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the under	ving cause given	in Part I	23e Did toba	CCO Use contribute to	the cause of death?
been signed by th should be detache	O.	ALCOHOLIC	CIRRHOSIS	4.1	, g g		1 ☐ Yes	-	obably 4 □Unknown
90	piete	PORTAL M	YELTENSION				24a. Was an	24b. Were at	itonsy findings available
O TO	Completed	130	11-1-1		_	1	autopsy performe	ed? death?	utopsy findings available completion of cause of
ate has b	Q	25. Was case referred to medical examiner?			2	26. Place of Dea	1 ☐ Yes 21 ath (Check anly one)	,	2 NO
Inelaw ate has b page 2 sl	Be	gyattiligi :		ER/Outpatient 3	☐ DOA Other:	4 Nursing H	ome 5 🗆 Residen	ce 6 □Other (Spe	cify)
vsicien: The law s certificate has b director, page 2 sl	To Be	1 X Yes 2 X N o	200 Date of Laive	28b. Time of	28c. Injury a Work?		28d. Describe how	injury occurred	
ng Physicien: The law ifter this certificate has b uneral director, page 2 sl	2	27. Manner of Death 1 ☒Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury		s 2 No			
ding ruysicien: the law h. After this certificate has b funeral director, page 2 sl	2	27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigati 3 □ Suicide 6 □ Could not	(Month, Day Year)	٨			296 Location (Ctra	at and Minnter	1.00 1.11.1
Accounting Trystoen: The law fer death. irector: After this certificate has b i by the funeral director, page 2 st	2	27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	ome, farm, street, f			28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
or Attending Prhysicien: The law let death. The law irector: After this certificate has b to by the funeral director, page 2 st	Certification; To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying P	(Month, Day Year) 28e. Place of Injury - At he building, etc. (Specifications)	ome, farm, street, f	actory, office	, date and place	City or Town,	State)	
for death. if or death is certificate has b if or the funeral director, page 2 st	ledical Certification; To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 27. Manner of Death 5 Pending investigate 6 Could not determine	(Month, Day Year) on 28e. Place of Injury - At ho	ome, farm, street, f	urred at the time, gation, in my opin	nion, death occu	City or Town,	State)	
fer death. irector; Atler this certificate has b n by the funeral director, page 2 sl	ledical Certification; To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying P	(Month, Day Year) 28e. Place of Injury - At he building, etc. (Specifing) hysician: To the best of my knominer: On the basis of examina and manner stated.	ome, farm, street, f y) wledge, death occ tion and/or investion	urred at the time, gation, in my opin	nion, death occu	, and due to the cau rred at the time, date	se(s) and manner as and place, and due Date signed (Monti	stated. to the cause(s) h, Day, Year)
Accounting Trystoen: The law fer death. irector: After this certificate has b i by the funeral director, page 2 st	Medical Certification; To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	(Month, Day Year) 28e. Place of Injury - At he building, etc. (Specific Management of	ome, farm, street, f y) wledge, death occ tion and/or investig	urred at the time, gation, in my opin	nion, death occu	, and due to the cau rred at the time, date	State) se(s) and manner as a and place, and due	stated. to the cause(s) h, Day, Year)
ding Physicien: The law h. After this certificate has b funeral director, page 2 sl	Medical Certification; To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 27. Manner of Death 5 Pending investigate 6 Could not determine	(Month, Day Year) 28e. Place of Injury - At he building, etc. (Specific the specific ome, farm, street, f y) wledge, death occ tion and/or investion	urred at the time, gation, in my opin 29c. License r	nion, death occu	, and due to the cau rred at the time, date	se(s) and manner as and place, and due Date signed (Monti	stated. to the cause(s)	

			1 - For Registrar	State of M		Depa		of H	ealth a	and Me	ental Hyg	giene nog. No.2 0 0 5	12202
	Physic /Medi		Decedent's Name (First, Middle, La O	•	TTA	FIS	HER				2. Date of Dea Month		
	Examir		4a. Facility Name (If not institution, giv LORIEN NURSING	CENTER				ANE	TOW	of Death		4c. County of De	ath
	Funeral Director		5. Social Security Number 6. S 219-66-4642 Usual Residence of Decedent	ΘX 7. Aα	ge (In yrs. last b	Yrs.	If Under 1 Months	Days	If Under: Hours	Min.	8. Date of Birth (Month, Day 1AY 4,	r, Year) (irthplace (State or Foreign Country) RYLAND
	Maryland	ctor	MD • CARROI	ıL	10c. City, To WE		cation INSTE	R					10d. Inside City Limits 1 X Yes 2 □ No
	with the ta or 28	Dire	10e. Street and Number	CE DD			10f. Zip (Code 2115	- ~7			10g. Citizen of What (Country?
9036	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "naturel", or Itams 23a or 28e-f ahow event, if a Marical Exerting Franke.	by Funeral Director	102 TIMBER RID 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?	1		ent of His fy Cubar	panic Orig , Mexican	gin? (Spec , Puerto R	cify Yes or No- lican, etc.)		ite, etc.
21215-0036	d within 72 h giene. or than "natu it e M. dical	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	ducation ide completed) College (1-4or		(Give	lent's Usual kind of work DO NOT use FARI	done di e retired)	uring most	of working	g	16b. Kind of Busines	
Maryland		To Be C		ON E. MY					M	ARY	ETTA I		
	d 2 s th an 7 is treu		19a. Informant's Name/Relationship (C. DEAN STARNE)				-					r, City or Town, State, YTOWN , M	
Baltimore,	nit. Pages 1 an artment of Heal ortent: If item 2 Injury or other g.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 6 ☐ Other (Specification)	()	20b. Place cemet KRIDE	ery, cren CR 'S	CEMI	er place ETEI	RY 3		05 V	20c. Location - City of VESTMINS	TER, MD.
Ball	permit. Popartm Importer any Injure once.		2 Sign F. Fa Service Line	See		100						FUNERAL NSTER, MI	
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that cause one cause on each l	ine.			, ,					Approximate Interval Between Onset and Death
8760,	Medical Examiner Associate and period transit	i Examiner	S - yuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Litt Due to (or as	a consequence	a or):	tu	Vas	enl	n k	lisen	1-	25yr
P.O. Box 687	death certificate e attending phy id for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal deat		Ectopic pred					23d. Date of di Month	alivery Day Year
	ires tha signed d be de	by	Part II. Other significent conditions of	ontributing to death b	out not resulting	in the un	derlying cau	use giver	n in Part I.		23e. Did tot	fra:	to the cause of death?
al Records,	The ate his page	Completed									24a. Was a autops perform	sy prior to	utopsy findings available completion of cause of
f Vital	nysician: nis certific i director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatio	ent 2 ER/C	utpatien	3□ DOA	Other	4		Check onlon 5 □ Reside	ence 6 Other (Sp.	ecify)
Division of	Attending Physician: r death. sctor: After this certific. by the funeral director,		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		lry 28b.	Time of Injury	M 286	c. Injury a Work? 1 🗆 Yo	at es 2 □ N		ld. Describe ho	ow injury occurred	
Divi	in Direction	Certification:	3 Suicide 6 Could not be determined	building, et	tc. (Specify)						City or Towr		
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	one)	and manner st	f examination a ated.	nd/or inv	estigation, in	n my opi	nion, deat	h occurred	at the time, da	ause(s) and manner a ate and place, and du	e to the cause(s)
)		4	29b. Signature and title of certifier	uddlet	سر بر	p	29c.	License	number	3 3	2	3/23/2	th, Day, Year)
	MIST		30. Name and address of person who	completed cause of c	death (Item 23a)	(Type, F	Print)	our	1. L	Neal	m 12 51	ler, mi	21157
	Sta Registr		31. Date filod (Month, Day, Year) MAR 2 5	2005 32. Recons	ar's Signature	* 1	food	,	•/			9d. Date signed (Mor 3/23/2	•

			1 - For State Registrar	State of Ma	arylan		artmen <i>rtificat</i>				lental Hy	gien	200	5	12203
	Physic		Decedent's Name (First, Middle, Last CLYDE FOSTER	st)							2. Date of De Month MARCH	D.	2005 Y	9 <i>9</i> r	3. Time of Death 10:45 PM
	/Medi Examir		4a. Facility Name (If not institution, given 1633 OLD TANEYTO	e street and number) WN ROAD					Location o	of Death	PARCH		c. County of		10:45 PM
	Funeral Director		5. Social Security Number 6. S 425–20–1600 Usual Residence of Decedent	ex 7. Ag □M 2□F	e (In yrs. 82	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da AUGUST	iy, Year	1922		ace (State or Foreign ry) SSISSIPPI
	anyland show	J.	10a. State 10b. County			y, Town or Lo								10	d. Inside City Limits
	the M	ecto	MARYLAND CARROLI	<u>, </u>		WESTMI	NSTER 10f. Zip	Carla				10- 0	W 114fb		1 Tes 2 No
	h with	ai Dir	1633 OLD TANEYTOW	N ROAD				1158				_	itizen of Wha TED S'		
980	72 hours after death with the Maryland naturel', or Items 23e or 28a-f show Jisal Examirer must be notified at	by Funeral Director	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ¬Yes 2 □ I If Yes, Give Year or Dates:			Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.))-	14. Race - Black, Specify:	America White, e	tc.
21215-0036	be filed within 72 hours ital Hygiene. Ind other then "naturel", svent, Ine Manical Exp	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced	lent's Usua kind of wor DO NOT us	k done di	uring most	of worki	ing	16b. I	Cind of Busin	ness/Indi	ustry
212	d within giene.	omo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	HEAV				ATOR		С	ONCRE!	Œ	
Maryland		To Be C	17. Father's Name (First, Middle, Last) JAMES FOSTER								(First, Middle,	, Maidei	Sumame)		
Man	d 2 she h and 7 is m treum		19a. Informant's Name/Relationship (TEVELYN I. FOSTER/V				g Address OLD '				I Route Number				
	1 an Heal em 2 ther		20a. Method of Disposition XXBurial 2 □ Cremation 3 □		20b. P	lace of Disposemetery, cren	sition (Nan	ne of	1		D, WES		NSTER , ocation - Cit		21158 vn, State
Baltimore,	Pant and		'4 Donation 5 Dother (Specify)		ADOW BE	RANCH	CEME	TERY	,	/25/05	WE	STMINS	STER	, MARYLAND
Ba	permit. Departrimports any inju		21. Signature of Funeral Service Licen	Hop hout	ist		Name an	-DURF	3ORAW	FUN	ERAL HO	ME,	P.A.	_	044==
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. CHR	onic	RE	er the mode	of dying		cardiac o	WESTP r respiratory a	TINS	TER, A		Approximate Interval Between Onset and Death U CACA
8760,	eate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as Due to (or as d.	a consequ	vence of):	51 W								
.O. Box 6	death certifi e attending I id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre Other (spe						23d. Date o Month		/ Day Year
Ω.	requires that the een signed by th hould be detache	by	Part II. Other significant conditions of MCM INSULW (ontributing to death be	ut not resu	ulting in the un	derlying ca	iuse giver	n in Part I.		23e. Did to		1		cause of death?
of Vital Records,	The law ate has b page 2 sl	Completed	perphenal va	sculte e	sidec	Me					24a. Was autop perfor		prior	to comp	sy findings available pletion of cause of
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				Other	,		(Check only o	ne)			
on of	nding Phys th. : After this s funeral di	ıtion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Injur (Month, Day	y	ER/Outpatient 28b. Time of fnjury		Bc. Injury a	4 🗀 1401		ne 5 Resid		6 □Other (Specify)	
Division	al or Atters s after des	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Inju- building, etc	ury - At hor c. (Specify	me, farm, stre	et, factory,	office		2	8f. Location (S City or Tow	Street ar m, State	nd Number o	r Rural I	Route Number,
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After thi completely filled in by the funeral	Medicai C	29a. Certifier (Check only one) 12 Certifying Phyone	rsicien: To the best of iner: On the basis of and manner sta	examinati	wledge, death ion and/or inv	occurred a estigation,	t the time	, date and nion, death	place, a	nd due to the cod at the time, c	cause(s)	and manne d place, and	r as stat due to ti	ed. he cause(s)
	To t To tl	ž	29b. Signature and title of certifier				-	License				29d. Da	te signed (N	lonth, Da	ay, Year)
,	WSVA		20 Nove and	omalated and	-AL (1)	00-) =		١).	516	96	0 (すい		
	MINA		30. Name and address of person who carry THOMAS K. GALVIN I				,	TTF	203	TATES	STMINST	ED.	MD 2	1157	,
:	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 4	32. Registe	r's Signat	ure				441.16	LCKITINGL	ر الل	2 - لنات	1157	

				State of Maryland				•	•	
			1 - For State Registrar	State of Maryland	-	tificate of			2015	12204
			Negistrar Decedent's Name (First, Middle, Last)		061	lineate of	Dealii	2. Date of Death	g. No.	3. Time of Death
	Physici		Byron Wilbur	Fairall				Month /	722005	9:310
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, o	or Location of Death	MAIN	4c. County of Death	1 1 1
			Vorinester Ge	neial		Camb	ndac		Wiche	ster
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	ear) Cou	plece (State or Foreign
	Director		218-12-1211 Usual Residence of Decedent	80	Yrs.			Oct. 27		rýland
	land ow		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
ς	Many a-f sh	tor	MD Dorches	ter		Cambr	ridye			1' ∑ Yes 2 ☐ No
3	or 284	lired	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cou	ntry?
3	23e	Funeral Director	411 Leonard Lane				21613		USA	
0	tems	nne		Was Decedent Ever in U.S Armed Forces?	. 13. \	Vas Decedent of H Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	rs afte	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 XXYes 2 □ No If Yes, Give Year or Dates: WW∏	1	□Yes 2, X No	Specify:		Specify: wh	
21215-0036	ature	edt	15. Decedent's Educa		16a. Deced	ent's Usual Occup	pation	16	Sb. Kind of Business/Ir	
215	hin 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done OO NOT use retire	during most of worki	ing	SE. Tana or Basinosan	idastiy
	be filed within 72 hours atter death with the Maryland ital Hyglene. d other than "naturel", or items 23e or 28e-f show event, the Medical Enaith an implied at	Completed	11		n	arine po	liceman		state gove	rnment
nd	be filk tal Hy d oth event	Be (17. Father's Name (First, Middle, Last)	_				(First, Middle, Ma	iden Sumame)	
<u>\</u>	outd Men Parke	7	Philip R. Fairal					Meekins		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or items 23e or 28e-1 show any injury or other traumatic event, the Medical Enaith activities be retified at once.		19a. Informant's Name/Relationship (Type	1					City or Town, State, Zi	o Code)
	1 and Healt tem 2		Elizabeth Fairall 20a. Method of Disposition	wife 20b. Pla	ce of Dispos	sition (Name of	Lane, Cam		MD 21613 oc. Location - City or T	own State
ē	ages ant of it: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	netery, cren	atory or other plac	· 1			
Baltimore,	mit. F partme ortar injur		21. Signature of Funeral Service Licenses				.1 Park 3/.		Cambridge, cal Home P.	A.
ä	Depa Impo		Bruin K. BITT				t St., Car			
	100		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death,	Do not ente	er the mode of dyir	ng, such as cardiac c	r respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Coronar	u A	rtery		rase		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	noe of):	1				
		_	Sequentially list conditions, b.	Due to (or as a conseque	noo off:					
	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events c.	Due to (or as a conseque	ilice oi).					
,	te be executed ysician and ie burial-transit	Examiner	resulting in death) Last	Due to (or as a conseque	nce of):					
760		cal	d.							
89	death certifica e attending ph of for use as th	Med	IF FEMALE:							
Вох	ath ce ttendi or use	an/I	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal d		Ectopic pregnancy	,		23d. Date of deliver	,
0	the a	Physiclan/Med	1 Yes 2 No	4☐Pregnant at time of dea 9☐ Unknown	th 5 ☐	Other (specify)			Morth	Day Year
Q.	that the ed by detact	Ph	Part II. Other significant conditions contr	ibuting to death but not resulti	ing in the un	deriving cause giv	en in Part I	23e. Did tobac	cco use contribute to t	he cause of death?
Records,	The taw requires that the tae has been signed by th bage 2 should be detache	d by				, ,		1 🗌 Yes	. /	pably 4 Unknown
<u> </u>	s been si	Completed						24a. Was an	24b. Were auto	psy findings available
	The lav te has	om				-		autopsy	d?/ prior to co death?	mpletion of cause of
Vital	ien: ntifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Death		No 1 ☐ Yes	2 No
	Physicien: The la r this certificate has	2	1 Yes 2 No	spital: 1 Inpatient 2 F	VOutpatient	3□ DOA Oth	er: 4 Nursing Hon	ne 5 🗆 Residenc	e 6 □Other (Specif	iy)
Ē	ding Ph h. After thi funeral	on:	27. Manner of Death 1 ■ atural 5 □ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injur Work	y at k?	8d. Describe how		
Division of	ttend death stor: ,	icat	2 Accident investigation 3 Suicide 6 Could not be	39a Dines of Injury At hom	o form stre		Yes 2 □No	19f Location (Street	at a sed fill seeks a set Down	d Courts At only
2	lor A after Direct I in by	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, raim, stre	et, ractory, office		City or Town, S	et and Number or Rura State)	ii Houte Number,
	spite hours inerel y fillec		29a. Certifier 1 Certifying Physic	ian: To the best of my knowle	edge, death	occurred at the tin	ne, date and place, a	ind due to the caus	se(s) and manner as s	tated.
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medical Examina	r: On the basis of examination and manner stated.	n and/or inv	estigation, in my o	pinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
	To the total	Σ	29b. Signature and title of certifier			29c. License	e number	29d.	Date signed (Month,	Day, Year)
			State M'D			0005	7040	03	1/22/200	5
			30. Name and address of person who com				00=		21/13	
	K. Cto		BRENDON PALTO				AMBRIDGE	-, MO	4013	
	Sta Registra		DAK 2 4	TOUS TOUR	A.	And I				

			1 - For Registrar	State of M		d / Depa		t of H	ealth a	and M			3005	12205
	Physici	an	1. Decedent's Name (First, Middle, Li	•							2. Date of Dea		y Year	3. Time of Death
	/Medic		Bobbie M. F	iore			,				March 2	22,	2005	5:00 a M
	Examir	er	4a. Facility Name (If not institution, gi)				Location	of Death		1 -	. County of Death	
	*		Shady Grove Adv		4		Rock			0411-			Montgomer	
	Funeral Director			Sex 7. Ag		0 Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day Jan. 3	Year)	9. Birthp Coun 925 Cali	lace (State or Foreign try) fornia
	yland		10a. State 10b. County		10c. City	y, Town or Lo	cation						10	Od. Inside City Limits
	Mar Hilled	ctor	Maryland Montgo	nery	Gai	thersb	ourg							1XYes 2□No
	or 28	Oire	10e. Street and Number				10f. Zip				1	0g. Cit	izen of What Coun	try?
	ath w	ral	353 Winterwalk D	rive				.0878				Ţ	J. S. A.	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury of other traumatic event, the Medical Exaft har must be invilled at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 2 If Yes, Give Year or Dates:	?	}	Was Deced f Yes, spec 1 Yes 2		spanic Ori n, Mexicar Specify:		ecify Yes or No- Rican, etc.)		14. Race - Americ Black, White, e Specify: Wh	
ŏ	2 hou	ted	15. Decedent's E	ducation		16a. Deced	dent's Usua	Occupa	ation			16b. K	ind of Business/Inc	lustry
215	hin 7	ple	(Specify only highest gi Elementary/Secondary (0-12)	ade completed) College (1-4or	5+)	(Give	kind of wor DO NOT us	k done a e retired,	furing mos)	it of worki	ng			
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pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las	1)							(First, Middle, I		,	
yla	ould Men Parke	2	Cecil C. Brown								ne Von I			
Nar	l 2 sh and r Is m		19a. Informant's Name/Relationship										or Town, State, Zip	
e,	1 and Health em 27		Charles J. Fiore 20a. Method of Disposition	- Son							_		rsburg, M	
Jor	ages nt of 1		1 Burial 2 Cremation 3		l l	lace of Dispo			- 1				ocation - City or To	
Ħ	it. Pi		 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice 		Liv	e Oaks							rovia, Ca	lifornia
Ba	Deporting any i		Domald C	1)-	nest	ž Éd	lward	Sage	el Fu	inera	1 Direc	tio:	n, Inc. e, Maryla	and 20852
			23a. Part1. Enter the disease, or con shock, or heart failure. List only				er the mode	of dying	g, such as	cardiac o	r respiratory arre	est,	e, Haryre	Approximate
	Pnysician :		Immediate Cause (Final	one cause on each i Resp	_{ire.} irato	ory Fa:	ilure						Į.	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as										
E	Examiner			Shoc										
	D =	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	ience of):	160314720	es as	1.0		1 T C			
	nd nd transi	Examiner	that initiated events	C			arctio	on a	na Ce	rebr	al Infa	ret	1011	
8760,	ate be executed hysician and the burial-transit	EX	resulting in death) Last	Due to (or as	a consequ	ience of):								
		dical		_ d.			_					_		
9 X	death certific e attending pl id for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnar	nev						T		
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{ Yes} 2 \subseteq \text{ No} \)	1 ☐ Live birth	2 Fetal	death 3	Ectopic pre						23d. Date of deliver Month	y Day Year
o.	0 0	ysi	1 ☐ Yes 24 No 9 ☐ Unknown	9□ Unknown		,u.,,	Ollioi (Spe	Ç11y/						
S, P	de ad	by Pr	Part II. Other significant conditions	contributing to death b	out not resu	Ilting in the ur	nderlying ca	use give	n in Part I.		23e. Did tob	acco u	ise contribute to the	a cause of death?
rds	quires n signe										1 □ Ye	s 2	□No 3 □ Proba	ably 4 Unknown
Record	aw requir as been si 2 should	ompieted									24a. Was a	n	24b. Were autop	sy findings available
R	The lay ate has page 2	mo					_				autops	ned?	prior to com death?	spletion of cause of
Vital	ysician: The is certificate hadirector, page	le C	25. Was case referred to medical						26. Place	of Death	1 Yes 2	No (A)	1 ☐ Yes	2□ No
	Physician: this certifice ral director, I	To B	examiner? 1 ☐ Yes 2 ☐ X No	Hospital: 1 XInpatie	ent 2 🗆 E	ER/Outpatient	t 3 🗆 DO	Othe					6 Other (Specify,	
n of	ding Phy h. After thi funeral o		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28	c. Injury Work	at ?		8d. Describe ho			
Sio	r Attending er death. ractor: After by the funer	catio	2 Accident investigation				М		es 2 🗆 1	No				
Division		ertification:	3 Suicide 6 Could not be determined		ury - At hor c. (Specify,	me, farm, stre)	eet, factory,	office		2	8f. Location (Str City or Town		d Number or Rural)	Route Number,
		O	CO- Continue ATT Continue B											
		edicai	29a. Certifier 1 Certifying Pl	nysician: To the best miner: On the basis of and manner st	f examinati	viedge, death ion and/or inv	occurred a restigation,	t the time in my op	e, date and inion, deat	d place, a th occurre	nd due to the ca d at the time, da	iuse(s) ite and	and manner as sta place, and due to	ited. the cause(s)
	within 2	Me	29b. Signature and title of certifier		2100.		29c.	License	number		29	d. Dat	e signed (Month, D	Pay, Year)
)	مرحة ا		0 ///					D006	1681				ch 22, 20	
	>		30. Name and address of person who	completed cause of d	leath (Item	23a) (Type. F	Print)							
			Dr. Robert Kirl	caldy 990:	l Med:	ical C	enter	Dri	ve, I	Rockv	ville, M	lary	1and 208	350
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signati	ure A	H. D							
	Registr	ar	MAR 2 5 20	05 Store	, 5.	14								

State of Maryland / Department of Health and Mental Hygiene 115

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Edge Examiner Edge Examiner Edge Examiner	ace (State or Formy) and In lod. Inside City Lin I □ Yes 2 ፵ In Indian, Interpretation White ustry Code)
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17. Father's Name (First, Middle, Last) Joseph Jenkins 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 20a. Method of Disposition 1EXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fulleral Service Licensee 22. Name and Address of Facility 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the state of th	1 □ Yes 2 ঈ
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Joseph Jenkins Signature of Furer the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Joseph Jenkins Eliza Brown 18. Mother's Name (First, Middle, Maiden Sumame) Eliza Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 811 Valley View Drive, LaVale, MD 21502 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Restlavm Memorial Gardens 20b. Place of Disposition (Name of cemetery, crematory or other place) Restlavm Memorial Gardens 21. Signature of Fureral Service Licensee 404 Decatur Street, Cumberland, MD 21502	vn, State
Joseph Jenkins Signature of Furest, Middle, Last) Joseph Jenkins Joseph Jenkins Signature of Furest Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) Eliza Brown 19a. Informant's Name/Relationship (Type, Print) Gary L. Geiger / grandson 20b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Furest Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, And Stelland 18. Mother's Name (First, Middle, Maiden Sumame) Eliza Brown 20c. Location - City or Town cemetery, crematory or other place) 22b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gardens 22c. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502	vn, State
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snock, or heart failure. List only one cause on each line.	
sician	Approximate
edical Immediate Cause (Final disease or condition Caranoma of Pancreas	Interval Between Onset and Death
disease or condition	mont
resulting in death)	
e l	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitted events.	
Cause Diversity of Cause (Disease or injury that initialed events resulting in death) Last Due to (or as e consequence of):	
Fesulting in death) Last Due to (or as θ consequence σ):	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the	he cause of dea
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the 1 Yes 2 No 3 Probable 24a. Was an autopsy performed? 24a. Was an autopsy performed?	0
Per de la la la la la la la la la la la la la	., 9
24a. Was an autopsy 24b. Were	e autopsy finding
24a. Was an autopsy performed? 24b. Were availa comp of dee	lable prior to pletion of cause eath?
	Yes 2□ No
25. Was case referred to medical 26. Place of Death (Check and and	
examiner?	
To the 27 Manner of Death 200 Date at Injury 200 Time of 200 January 200 Death 1 1 2 2 2	
1 D Natural 5 Pending (Month, Day Year) Injury Work?	
2 Accident investigation M 1 Yes 2 No 2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 4 Homicide 4 Hom	Route Number
27. Manner of Death Arganization 298. Date of Injury 288. Time of Injury 288. Injury et Work? Accident 3 Suicide 4 Homicide 1001011201	
29a. Certifier 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state	lad
1 Production 2 Pr	ne cause(s)
29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Da)	av. Year)
() promo D0033280 March 17	1 200)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Spril V. Cupto M.D. 625 Kent Avenue Cumberland MD 21502	
Shift R. Supta, 11.D., 025 Rent Avenue, damperland, 115 21302	
State 31. Date filed (Month Dar, 1997) 2005 Registrar Registrar	

	State of Maryland / Department of Health and M 1- State of Maryland / Department of D	
	Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
Physician	GENNIEVE CECILIA GRAY	MAR 24 2005 12.40 A
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	MAR 24 2005 12:40 A 4c. County of Death
- Ladimile.	CIVISTA MEDICAL CENTER LAPLATA	CHARLES
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month Day Year) 9. Birthplace (State or Foreign
Director	220–16–7796	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) MARYLAND
Pur 🛊	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
farylan ehow		1 ☐ Yes 2 ☐ No
the Ma 28e-f	MARYIAND CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
€ 5 €	5915 MASON SPRINGS ROAD 20640	UNITED STATES
death w	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe	
after dea	1.A Never Married 2 Married 1 Yes 2.A No	
033 ours	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Specify: BLACK
5-00.	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin	16b. Kind of Business/Industry
E1215-003(ed within 72 hours a ygiene. Parthen "neturel", of the Medical Exa	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	l l
11. (1) # 5 - 3	11TH GRADE POWDER EXPLOSIVES WORKE 17. Father's Name (First, Middle, Last) 18. Mother's Name	R FEDERAL GOVERNMENT (First, Middle, Maiden Surname)
and and de fill antal H sed out c even	PRESTON GRAY CORA SWAN	
aryland should be should be smarked o umetic eve	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	
00 00 00		, INDIAN HEAD, MARYLAND 20640
other tree	20a. Method of Disposition 20b. Place of Disposition (Name of	late 20c. Location - City or Town, State
Pages nent of inty or o	t 200 unat 2 Cremation 3 Chemoval nom 3/2/6	B1, 2005 GLYMONT, MARYLAND
Balt Balt Depart Import any inj	IADIA C. THORNTON JUHNSON MOO583 THORNTON FUNERAL HOME, F	A NDIAN HEAD, MARYLAND 20640
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	
Pnysician	The state of the s	RREST Onset and Death
/Medical		
Examiner	Sequentially list conditions, Due to (or as a consequence of): ATHERO-SCLEROTIC HEART	DISEASE
P = D	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	
D, executed in and ial-transit	Cause (Disease or injury that initiated events c	
	Due to (or as a consequence of):	
	V d	
Box 68' eath certificat attending phy ifor use as th	IF FEMALE: 23c. If yes, outcome of pregnancy	COL Data of delivery
Box eath cert attending for use a	in the past 12 months?	23d. Date of delivery Month Day Year
O. the dy the ched	1 Yes 2 No 9 Unknown 9 Unknown	
cords, P.O. Be wrequires that the death been signed by the attershould be detached for the detached by Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
rds quires	SEPSIS	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
CO) IW Fector S bee	DIABETES	24a. Was an 24b. Were autopsy findings available prior to completion of cause of
Division of Vital Records, P.O. Box 68 or attending Physician: The law requires that the death certifical birector: After this certificate has been signed by the attending phin by the funeral director, page 2 should be detached for use as the rification: To Be Completed by Physician/Med	CHRONIC OBSTRUCTIVE LUNG DISEASE	performed? death?
/ital	25. Was case referred to medical 26. Place of Death	
f Vita yeiclen: is certific director,	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Hon	ne 5 Residence 6 Other (Specify)
on o' ding Ph After th funeral		8d. Describe how injury occurred
Sion teath. tor: At the fu	2 Accident investigation M 1 Yes 2 No	
Division of Nite or Attending Physics after death. el Director: Atter this control by the funeral director or Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Doitef of urs af order of order orde		
Division of Vital Records, P.O. Box 68 To the Hospitel or Attending Physicien: The law requires that the death certificat within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medi	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a place, and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause(s) and manner as stated. Indicate the time, date and place, and due to the cause(s)
thin 2 the mplei	one) and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
F 3 F 8	1/ Annangarting	03-24-2005
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
BI	ANMANGANDLA VIDYASAGAR MD RT 5&GOLDEN BEACH R	282 D.CHARLOTTE HALL MD 2062
State	31. Date filed (Month, Day, Year) MAR 2 8 2005 32. Redistrar's Signature	THE ZUD Z

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Palmer Grant Jr. 05 - 2320DOS 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** Palmer Grant, Jr. 2005 April 2 0849 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1⊠M 2□F Yrs. Director 218-48-6215 57 MD Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show evant, the Medical Examiner must be notified at 1 XYes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Itams 23a 218 Wall Street 21801 Funerai U.S. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Roofer Construction 12 and Mental Hygie permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: If Item 27 le markad other any injury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Palmer Grant, Sr. Ora Stevenson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Beulah Grant/wife 218 Wall St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crematory of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 4/8/2005 Delmar, DE Delmarva 21. Signature of-Fufferal TO AND 22. Name and Address of Facility 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Lewis N. Watson Funeral Home Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mixed Drug(Heroin and Cocaine)intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) o detached 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2□No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 2 1 X Yes 2 ☐ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? unk 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After Found: unk 5 Pending investigation 1 Natural 1 □ Yes 2 X No death. 4-2-05 2 Accident Diractor: 6 Cauld not be determined 3 Suicide 28f. Location (Street and 1015 of Challevin NuStreet City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide Salisbury, Wicomico County, MD Found:private dwelling To the Hospital within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 3, 2005 OCME

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Mont)

111 Penn Street Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Paistrar's Signature

6 2005

			1 - For State Ragistrar	State of	Maryland	•			lealth an <i>Death</i>	d Mental H	lygier Reg. N	2001	5 1220
			1. Decedent's Name (First, Middle, I	ast)						2. Date of Month		You You	3. Time of Death
d l	Physici /Medi		FRIEDA			GO	LDSMI	TH		MARCH	24,	2005 Yee	9:00 A M
	Examir		4a. Facility Name (If not institution, g	ive street and num	ber)		4b. City,	Town, o	r Location of D	eath	4	4c. County of De	ath
			6111 MONTROSE RO	AD #811				ROCI	KVILLE			MON	TGOMERY
	Funeral Director		5. Social Security Number 6. 119–16–6514	Sex 7 1 ☐ M 2 🔀 F	. Age (In yrs. la		If Under Months	1 Year Days	If Under 24 Hours	8. Date of (Month, 09/07	Birth <i>Day, Y</i> ea /19 2	9. B 23 PO	irthplace (State or Foreign Country) LAND
	D .		Usual Residence of Decedent		1								
	rylar	_	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	e Ma	cto	MARYLAND MONTGO	MERY			ROC	CKVI	LLE				1 ☐ Yes 2 🛣 No
	7 th	Director	10e. Street and Number				10f. Zip	Code			10g. (Citizen of What (Country?
	15 wi	ai	6111 MONTROSE RO	AD #811					20852			U.S.A.	
	dea	Funerai	11. Marital Status	12. Was Deced	ient Ever in U.S	3. 13.	Was Dece	dent of H	lispanic Origin	(Specify Yes or uerto Rican, etc.)	No-	14. Race - An Black, Wi	nerican Indian,
336	72 hours after death with the Maryland natural, or items 23a or 28e-1 ehow utal Examiner rout be notilied at	by Fu	1 Never Mamed 2 Married 3 Widowed 4 Divorced		No No		1 ☐ Yes		Specify:	30110 · 1104(1) 0101)			WHITE
15-0036	n 72 hor	Completed	15. Decedent's (Specify only highest of	grade completed)		16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	rk done	during most of	working	16b.	Kind of Busines	s/Industry
2121	with ene.	m C	Elementary/Secondary (0-12)	College (1-	4or 5+)		BOOF	KEE:	PER			GARMENT	
9	filed Hygi ther	Ö	17. Father's Name (First, Middle, La	st)					18. Mother's	Name (First, Midd	dle, Maid	en Sumame)	
an	d be antal	B	JACOB GOLDSMITH						HELEN	YAGOJINS	ΚI		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23a or 28e-f ehow minjoury or other treumatic event, the Mexical Examinat must be notified at ONCE.	To	19a. Informant's Name/Relationship HANNAH KRASSNER/							r Rural Route Nur SILVER S			
ā,	Hea Hea		20a. Method of Disposition			ace of Dispo			>	Date	20c.	Location - City	or Town, State
Baltimore,	Pages ment of ent: If I		1 ②xBurial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Special		เสเด เ	HEBRO				25/2005	FL	USHING,	NEW YORK
Balt	permit. Depart Import any Inj 20008.		21. Signature of Forneral Service Lic	7		E	DWARI	SAC	VIII.E P	ERAL DIR	KVII	ON, INC	YLAND 2085
			23a. Part1. In rine diseas in co shock, or leart failure. List on	mplications that ca ly one cause on ea	used the death ch line.	. Do not ent	er the mod	de of dyir	ng, such as car	diac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		RTENSIVI								Onset and Death
	/Medical		resulting in death)	Due to (o	r as a consequ	ence of):							
п	Examiner		Conventially list conditions	b									
		ner	Sequentially list conditions, if any, toauling to immediate cause. Enter Underlying	Dua to (o	и ав а вопезори	enes of):							
	xecuted and al-transit	xamin	Cause (Disease or injury that initiated events	c									
ó	0 5.2	Ĕ	resulting in death) Last	Due to (o	r as a consequ	ence of):							
68760	icate be ex physician s the buria	cai		d.									
	tifica ig ph as th	ed											
Вох	death certificate be e attending physicia d for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnar th 2 ☐ Fetal		Ectopic p	roonano	,			23d. Date of d	,
	deatle atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregna	nt at time of de		Other (sp				-	Month	Day Year
0		hys	9 □ Unknown	9□ Unknov	MΠ								
σ.	that	by P	Part II. Other significant conditions	s contributing to dea	ath but not resu	iting in the u	nderlying o	ause giv	en in Part I.	23e. Di	d tobacc	o use contribute	to the cause of death?
ds,	requires that the een signed by th hould be detache									1[Yes	2 No 3 1	Probably 4 Dunknown
Ö	> 0 0	lete								24a. W	as an	24b. Were	autopsy findings available
Record	e la has	Completed								_ au	itopsy informed?	prior to	completion of cause of
=										1 Te	2 2		
Vital	Physiclen: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Oth		Death (Check on			
of	Physical this call dir	. To	1X Yes 2 No	1 1010		P/Outpatier				ng Home 5 XR		6 □Other (Sp jury occurred	ecify)
on	iding Ph th. After th funeral	tion;	27. Manner of Death 1 □Statural 5 □ Pending 3 □ Accident investigat		, Day Year)	28b. Time o Injury	м	28c. Injur Wor	yat k? Yes 2∐No	ZOG. DOSCIIL	o now in	gary occurred	

Division of Vital Records, P.O. Box 68760, To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the fi

> State Registrar

Medical Certifica

3 Suicide 4 Homicide

29b. Signature and title of certifie

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year)

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Typo, Print)
DR. STEPHEN M. HELLMAN, 6240 MONTROSE ROAD, ROCKVILLE, MARYLAND

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D20674

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)
MARCH 24, 2005

			For State Registrar	State of Maryland / D	Department of Heat Certificate of Dea	ath	giene () () 5 Reg. No.	12210
			Decedent's Name (First, Middle, Last			2. Date of Dea	ath _	3. Time of Death
	Physici		Jeanetta Sadonn	a Harper		MARCH	16 2005 ear	2300 рм
	/Medic Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Loca	ation of Death	4c. County of Death	1
1			6300 blk CENTRAL A	AVENUE	SEAT PLESA	ANT	PRINCE GEO	RGES
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birt	hday) If Under 1 Year If U	Under 24 Hrs. 8. Date of Birth ours Min. (Month, Day	9. Birthp	lace (State or Foreign
	Director		220-23-6072	15	frs.	May 21,		ryland
	pug *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		1	0d. Inside City Limits
	faryli sho	5						1 ∑Yes 2 ☐ No
	r 28e-f show	Director	Maryland Prince 10e. Street and Number	George's	10f. Zip Code	1 Heights	10g. Citizen of What Cour	ntry?
	with Sa or			C.h.		0743	United St	
	Jeath ms 20	Funeral	1317 Oates	12. Was Decedent Ever in U.S.		nic Origin? (Specify Yes or No- lexican, Puerto Rican, etc.)		an Indian,
36	72 hours after death with the Maryland natural', or items 23a or 28e-f show alcal Examiner must be notified at	by Fur	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:		exican, Puerto Rican, etc.) pecify:		_{etc.} Lack
21215-0036	72 hours "natural"	ed b	15. Decedent's Edu		Decedent's Usual Occupation		16b. Kind of Business/Inc	
15	c 1 39	Completed	(Specify only highest grad	le completed)	(Give kind of work done during life. DO NOT use retired)	g most of working		,
212	filed within Hygiene. other than "	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Studen	+	None	2
Þ	I the	Be C	17. Father's Name (First, Middle, Last)			Mother's Name (First, Middle,		
ar	D 20 D	To B	Unknown			Shirle	ne Harper	
ary	s 1 and 2 should be if Health and Mental If Health and Mental Item 27 is marked other traumatic eve	Γ.	19a. Informant's Name/Relationship (T)	vpe, Print) 19b.	Mailing Address (Street and A	Number or Rural Route Number	r, City or Town, State, Zip	Code)
Σ	2 # Z		Elizabeth Harper/	Grand-mother	1317 Oates St	t., Capitol He	ights, MD 2	20743
Ore	of Hea of Hea fitem r othe		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ F	comotor	Disposition (Name of y, crematory or other place)	Date	20c. Location - City or To	wn, State
Ĕ	Page ment ant: h		* 4 ☐ Donation 5 ☐ Other (Specify)	Harmon	y Memorial Par	rk 3/26/2005	Landover	, MD
Baltimore, Maryland	permit. Pages Department of Important: If i any Injury or o		21. Signature of Funeral Service Licent		22. Name and Address of	Facility Stewart F	uneral Home	
-	20 F # 9		John S	leward, III		ng Rd., N.E. W)19
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.	e.	ich as cardiac or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a. Multij>/\$ Due to (or as a consequence of	14 Juns			Criset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of	of):	·		
-	_xaiiiiioi	er	Sequentially list conditions,	b. Due to (or as a consequence of	0			
	ed	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Day to for as a correspondence of	η,			
	xecul and	Examin	that initiated events resulting in death) Last	c. Due to (or as a consequence of	of):			
68760,	death certificate be executed e attending physician and of for use as the burial-transit	calE		d			1	
687	ficate g phys	ed		0.				
Box	leath certifi attending I I for use as	lan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	a 🗆 =		23d. Date of delive	ry
Ď.	death e atte d for	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
P.0	at the de by the i	Physici	9 DUnknown	9□ Unknown				
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause given in		bacco use contribute to th	
Vital Records,	w require been sig should b					1 🗆 Y	es 2 XNo 3 ☐ Prob	ably 4 □Unknown
900	e law re has be	ompleted				24a. Was a autops	an 24b. Were autop	osy findings available inpletion of cause of
B	he h	mo.				perfori	med? death?	2□ No
ita	certificat rector, pa	BeC	25. Was case referred to medical		26.	Place of Death (Check only on		
of V	d is	To	examiner? 1 XYes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Other: 4	☐ Nursing Home 5☐ Reside	ence 6 XOther (Specify	
0 _			27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury 28b. T (Month, Day Year) Ir	ijury Work?	28d. Describe ho	ow injury occurred	accillent
.0	Attending r death. ector: After by the funer	atle	2 Accident investigation	3/16/05 22:	46 M 1 □ Yes	2000 Passeuger	14 VOLVEL 14	me for Vehice
Division	r Att	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	City or Town		
	ital o	O		Str	uet	6300 (PL	tral Ave, Su	+ Plasantino
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edicai		sician: To the best of my knowledge iner: On the basis of examination and and manner stated				
	o the ithin 2 o the	Mec	29b. Signature and title of certifier	and manner stated.	29c. License num	mber 2	9d. Date signed (Month, I	Day, Year)
	⊬ 3 ⊢ ŏ		701 2	1100 Als	OCME	M	IARCH 17, 20	205
1	72	1	30. Name and address of person who co	ompleted cause of death (Item 23a) (EHCH 1/, 20	
K	2		ZABILLUI	TH ALI		Street Baltin	nore. Marvla	nd 21201
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature	~ _			
	Registr	ar	MAR 2 8 2005	Blanc # 1	grows.			

			1 - For State Registrar	State of Ma	- '	partment of ertificate of			Reg. No. 2	005	122				
	Physici /Medic Examir	cal	Jean Hershdorfer March								3. Time of Death 2005 8:30 P ^M ty of Death 3. Time of Death 4. Somery				
	Funeral Director			Sex 7. Age 1	(In yrs. last birthda 1 Yrs.	Months Days			0, 19	9. Birthe Coul	place (State or Fo ntry) ISylvani	oreign .a			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23e or 28e-f show any joint or other traumatic event, the Medical Eventher must be notified at Once.	Completed by Funeral Director	10a. State Montgo 10b. County MD Montgo 10e. Street and Number 11215 Seven Lock 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Orivorced 15. Decedent's E (Specify only highest girls and the state of	Is Road 12. Was Decedent E Armed Forces? 1 Yes 25 N. If Yes, Give Year or Dates: Iducation ade completed) College (1-4or 5-	16a. Dec		Specify: pation e during most of wo	Specify Yes or Norto Rican, etc.)	10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry U.S. Government			Limits No			
	permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If Item 27 is marked ott any injury or other traumatic even once.	To Be	17. Father's Name (First, Middle, Las Nicholas Pfursic 19a. Informant's Name/Relationship Judy T. Lapping/ 20a. Method of Disposition 1 © Burial 2 Cremation 30 1 Donation 5 Other (Spec 21. Signature of Funeral Service Lice	.h (Type, Print) Niece □Removal from State	20b. Place of Discometery, cr	iling Address (Stree 731 Crest position (Name of emalory or other pla B. CON. M 22. Name and Addred dward Sag 091 Rocky	Celia t and Number or R view Driv ace) EM. PK 3/ ess of Facility vel Funer	ve, Rock Date 28/2005 al Direc	ne er, City or To ville 20c. Locat WASHIN	M.D. ion - City or To	20854 own, State				
Examiner	Depression of the properties o	Physician/Medical Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. EMPHYSEI Lue to (or as a	FAIL consequence of):		ing, such as cardia	ac or respiratory a	rrest,		Approximate Interval Betwee Onset and Dea DAYS HRONIC				
.O. Box 68	death certific e attending p ed for use as	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the first outcome of the first outcome of the first outcome of the first outcome of the first outcome of the first outcome of the first outcome of the first outcome outcome of the first outcome outcom	Fetal death 3	□Ectopic pregnand □ Other (specify) _	ey		23d	. Date of delive	ery Day Yea	ır			
Vital Records, P.	requires been sign hould be	Completed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION 23e. Did tobacco use contribute to 1 Yes 2 No 3 Pro 24a. Was an autopsy performed?									nown ailable			
ō	ding Physician: After this certific funeral director,	ertification: To Be Co	25. Was case referred to medical examiner? 1 Yes X No 27. Manner of Death X Natural 5 Pending 2 Accident investigation			of 28c. Inju	her: 4 🗆 Nursing I	ath (Check only of Home 5 Resided Describe	2X No one) dence 6 X		topsy findings available completion of cause of 2 No				
Division	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	0	3 Suicide 4 Homicide 29a. Certifier (Check only) 21 Medical Exe	building, etc.	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) cien: To the best of my knowledge, death occurred at the time, date and place, er: On the basis of examination and/or investigation, in my opinion, death occur					d manner as si	al Route Number				
)	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier ### Company of the Company	and manner state	ed.	29c. Licen	se number	and at the time,	29d. Date si	igned (Month,	Day, Year)				
	Sta Registi		DOUGLAS R. SHUMAK 31. Date filed (Month, Day, Year) 2 8 2	ER, M.D., 6			Ave., Roo	ckville,	MD 20	1850					

State of Maryland / Department of Health and Mental Hygiene

					,	Certifica	te of i	Death		Reg. No.	CU	166	16	
		1. Decedent's Name (Fire	st, Middle, Las	1)					2. Date of De Month	Day	Year	3. Time of D		
Physici Medio/		SUE ANN	IDONI						MARCH	12, 2	005	7:00	P.M.	
Examir		4a Fecility Name (If not i	nstitution, give				4		or Location of Deat		ty of Death	NT37		
		DEVLIN	MANOR	NURSING			r 1 Voor	CUMBER			LEGA		Famian	
Funeral Director		5. Social Security Number 214–05–736		ox 7.Age □M 2 <u>X</u> 0F	(In yrs. lest bir	Yrs.	Days	Hours Mi		4,1917		place (State or intry) RYLANI		
p .	-	Usual Residence of Dece 10a. State 10b.	dent County		10c. City, Tow	or Location						10d. Inside City	y Limits	
sho			ALLEGA	ANY		BERLAN	D					1X Yes	2 🗆 No	
deeth with the Marylend ms 23a or 28a-f show rittust be notified at	Director	10e. Street and Number				10f. Z	ip Code			10g. Citizen of	f What Cou	intry?		
with gas of			OVER S	STREET		2	1502	2		U.S	. A .			
deeth ms 2;	Funerai	11. Marital Status	O TER E	12. Was Decedent E	ver in U,S.	13. Was Dec	edent of H	lispenic Origin?	(Specify Yes or N erto Rican, etc.)	o- 14. Re	ace - Ameri	ican Indian, . etc.		
72 hours efter deeth with the Marylen "natural", or items 23s or 28s-f show edical Examinar man be notified at	by Fur	1 ☐ Never Married 3 🛣 Widowed 4 ☐		Armed Forces? 1 ☐ Yes 2 X\n If Yes, Give Year or Dates:	lo			Specify:	ono moun, oro.,	Spec		WHITE		
2 hou		15.	Decedent's Ed	ucation	16a.	Decedent's Us	ual Occup	ation during most of t	workina	16b. Kind of	Business/I	ndustry		
l within 7 piene. r than "n	Completed	Elementary/Secondary		College (1-4or 5	+)			during most of v d)		HOM	CTP			
	So	12				HOMEM	IAKEI		lama (First Middle	HOME e (First, Middle, Maiden Sumame)				
e d ta b	Be	17. Father's Name (First										7NT)		
≥≥ = =	ို	BALDASSA		BELFOURE	101	Moiling Addre	es (Stroot		SEPPENA Rural Route Num		NOW			
CA @ 10 10	ĺ	19a. Informant's Name/				_			C, CHARLO					
ts 1 end of Health item 27 other te		PETER BA		/ 3011	20b. Place 9	f Disposition (N	ame of		Date	20c. Location				
90 = 5		20a. Mathod of Disposition Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ST. MARY S CEMETERY ST. MARY S CEMETERY O3/21/2005 CUMBER												
permit. Pag Depertment Important: I any injury o		21. Signature of Funera	Service Licen	isee		UPCH	and Addre URCH	ss of Facility FUNERAL	HOME, F	.A.				
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		23a. Part1. Enter the di shock, or heart fail	sease, or conflure. List only	olications that caused one cause on each lin	the death. Do ne.	not enter the m	ode of dyi	ng, such as care	diac or respiratory	arrest,		Approximate Interval Bety Onset and D	ween	
Physician											1			
/Medical Examiner		Immediate Cause (Fina disease or condition resulting in death)	I	a	Une	omn	-				-	19 de-	7	
	_	rooding in doding			Due to (or es a	consequence	of):				i			
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el-tre	Exai	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Enter Underlying C. Due to (or as a consequence of):												
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esth ignec	b		Lyn	77-6 1- 70	<i></i>				24a W	as an autopsy	24b.	Were autopsy f	findings	
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The law cete hes t										Yes 2 TN)	1 ☐ Yes 2 ☐	INU	
ysician: The s certificete director, pag	Be	25. Was case referred examiner?	to medical	Hospital:			004	About 100	Death (Check onling Home 5 - Re		Other (Sne	ncifu)		
S S	<u>۲</u>	1 ☐ Yes 2 ☐ No 27. Menner of Death		28a. Date of Inju		outpatient 3⊔ Time of	28c. Inju	S.L.PHUISI		e how injury oc		ich y)		
Jing After fune	tion	1 ☑Natural 5	☐ Pending investigation	(Month, Da	y Year)	Injury M		ork? ⊒Yes 2.⊒No						
l or Attending after death. Director: Aftei d in by the fune	fica	O L Galoido	Could not b	28e. Place of In	jury - At home,	farm, street, fac	tory, office	9	28f. Location	n (Street and Nu Town, State)	mber or R	ural Route Nun	nber,	
after Dire	Certification:	4 Homicide		building, et	ic. (Specify)				Only or	own, olato,				
To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai C	29a. Certifier 1E (Check only 2	Certifying Pl	hysician: To the best miner: On the basis o	of my knowledg	ge, death occurr and/or investigat	ed at the ton, in my	time, date and p	place, and due to the control occurred at the time	ne cause(s) and ne, date and pla	manner e	s stated. e to the cause(s)	
the H in 24 the F	edi	one)	-f	and manner st	ated.		29c Licer	nsa number		29d. Date sid	aned (Mon	th, Day, Year)		
Wilt To To	Σ	29b. Signature and title	or certifier	1, 2,			COU. EICOI	11136		m	14	2005		
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per:	01	30. Name and eddress	of person who	miner: On the basis of and manner st	death (Item 23a	(Type, Print)	,	62021	~ Mi	0 21	512			
ni		31. Date filed (Month,	Dav. Year	32. Redist	rer's Signature	1 /00								
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23. Part. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Projection Middlight Project ō,	1 an Heali Iem 2 other			20b. F	lace of Dispo	sition (Name of			, ,			
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Name of Death 2 Name o	Vita	icien	m	examiner?	Hospital		Oth	00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAMAR ZAMAN LOSS KENT Ave. Cumber and, MD 21502 State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	of	Phys this ral dir			1 ☑ Inpatient 2 ☐		N 3L DOA	4 Nursing Hor			ecify)	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAMAR ZAMAN LOSS KENT Ave. Cumber and, MD 21502 State 31. Date filled (Month, Day, Year) 32. Registrar's Signature		pspite hours unere		29a. Certifier Certifying	Physicien: To the best of my kno	wledge, deat	h occurred at the tin	ne, date and place,	and due to the cau	use(s) and manner a	is stated.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAMAR ZAMAN LOSS KENT Ave. Cumber and, MD 21502 State 31. Date filled (Month, Day, Year) 32. Registrar's Signature		he Hi in 24 he Fu pletel		one)	and manner stated.	tion and/or in	vestigation, in my o	pinion, death occurr	ed at the time, dat	e and place, and du	ie to the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAMAR ZAMAN LO35 Kent Ave. Cumber and MD 21502 State 31. Date filled (Month, Day, Year) 32. Regignar's Signature		With To 1	Σ	29b. Signature and title of certifier	20/		29c. Licens	e number				
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State			to				t HUE.	Lumber	rund,	IIID de	200	
							Coertes					

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Robert Jones 0400 AM 26 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 0. 40 Takoina Park Hos Montgomery Co. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** †**∑**M 2□F 64 Director Yrs. 219-68-8650 Aug, 17, 1940 NorthCarolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show other treumatic event, the Mudical Examiner must be notified at 1X Yes 2 No Funeral Director Prince Georges Mt. Rainier Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20712 USA 3001 Queens Chapel Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. XNever Married 2☐ Married I □Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2√2 No Black þ Specify: 3 Widowed 4 Divorced "netural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs Meat Cutter Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) rmit. Pages 1 and 2 should be filt partment of Health and Mental Hy portent: If item 27 is marked oth y injury or other treumatic event Be Riley Jones Dorothy Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $14908\ \ Jensford\ \ Court$ 19a. Informant's Name/Relationship (Type, Print) Fred Jones (Brother) Bowie, Maryland

20b. Place of Disposition (Name of cemetery, crematory or other place) 20721 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Department o Importent: If any injury or once. Mar.29,05 Riverdale, Md. Riverdale Crem. 21. Signature of Funeral Service Licensee Ralph Williams Funeral Service 767 1813 PotomacAve., SE; Washington, DC 20003 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Head cno Cencer 15 49644 PREK /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or najury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) the burial-transit and Due to (or as a consequence of): Box 68760, as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1XYes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? Yes 2X No 1 ☐ Yes Division of Vital director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 X Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospitel or Attending 5 Pending after death. 1 Tes 2 No 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 - Homicide filled in within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D0061462 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 202, Rockvill 700 31. Date filed (Month, Day, Year)
MAR 2 8 2005 State Registrar

			1 - For State of Maryla		artment of H		nd Mental F	lygiene Reg. No	71115	12215			
	Dhysisi	an	1. Decedent's Name (First, Middle, Last)				2. Date of Month	Death Day	/ Year	3. Time of Death			
	Physici /Medic		Raymond Brady	Jac	ckson		Marc		5 2005	3:22 A ^M			
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of	Death	4c.	County of Death				
			Frederick Memorial Hospi		Frede				Frederi	ck			
	Funeral		11€ M 2∏ F	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2		Birth Day, Year)	9. Birthp	place (State or Foreign ntry)			
	Director		234-58-8654 65 Usual Residence of Decedent	115.	<u> </u>		May 8,	1939	Kentu	cky			
	land			City, Town or Lo	ocation				1	0d. Inside City Limits			
	Mary	ō	Maryland Frederick	Frederi	ck					1 AYes 2 No			
	28a	Funeral Director	10e. Street and Number	-	10f. Zip Code			10g. Cit	g. Citizen of What Country?				
	3a or	ā	1500 W. Ninth Street		21701					1			
	me 2	Jera	11. Marital Status 12. Was Decedent Ever in	U.S. 13.		lispanic Origi	in? (Specify Yes or Puerto Rican, etc.)	No-	USA 14. Race - Americ				
9	72 hours after death with the Maryland netural; or Iteme 23a or 28a-f show Jical Examinar must be inclifted at		1 □ Never Married 2 ▼ Married 1 □ Yes 2 ▼ No If Yes, Give		_		Puerto Rican, etc.)		Black, White,	etc.			
8	ral',	d by	3 Widowed 4 Divorced Year or Dates:		1□Yes 2√PNo	Specify:			Specify: W	hite			
5	72 h 'netu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occup	ation during most of	of working	16b. K	ind of Business/In	dustry			
21	ithin ne. hen.	Id II	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done DO NOT use retire		, and the second	0-	1 0				
2	led w tygier her ti	S	6th		Carpenter		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			nstruction			
and	be fi	Be	17. Father's Name (First, Middle, Last)			18. Mother	's Name (First, Mid	dle, Maiden	Sumame)				
Ĕ	d Mer narke	^L	Charles Jackson				ntine		Hurley				
Maryland 21215-0036	12 st h and 7 ie n treun		19a. Informant's Name/Relationship (Type, Print) Carmela Jackson/Wife				or Rural Route Nui						
e,	1 and Healt em 2 ther				W. Ninti	Stree	et Frede		MD 21/0 ecation - City or To				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Integration of Health and Mental Hygiene. Integrate it if the Z7 is marked other than "netural; or iteme Z3a or 28a-f show any njury or other treumatic event, the Medical Examinat must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crei	matory or other pla k Cremato			655					
ij	t. Partmer rtant rtant		- Contains - Contain (opening)						erick, M				
Bal	Dep Impo		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Horacom 1621 Opossumtown Pike, Frederick, MD										
	48200		320 Both Sales the disease or complications that caused the de						ck, MD 2				
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ta		a	25. Was case referred to medical			26. Place o	1 ☐ Ye		1 105	2 140			
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0			27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur	y at	28d. Describ			,			
io	Attending in death. ector: After by the fune	atio	1	injury		Yes 2 □ No	0						
Division of Vital Records,	er de recto	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, str	eet, factory, office		28f. Location	n (Street an Town, State	d Number or Rura	l Route Number,			
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	Nospitel or Attend 24 hours after death Funerel Director: A stely filled in by the fr	edical	29a. Certifier (Check only Queen in the least of examiner) (Check	nowledge, deat	h occurred at the tir	ne, date and	place, and due to the	ne cause(s)	and manner as st	ated.			
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medi	and manner stated.										
,	With Congression	<	29b. Signature and title of certifier		29c. Licens		ð	1	e signed (Month, i				
,	0-		/ X lucker as		ŋ	3105	1	5/	25/05				
	9		30. Name and address of person who completed cause of death (If	em 23a) (Type,	Print)	,	1 . 1			2,790			
	Cha		31. Date filed (Month Pay Year) 32. Refistrar's Sig	POO (upperm	ino 1	MT WU	0116	UN MI) 0 1 / 10			
	Sta Registr		MAR 2 9 2005	Mr.	Society ?		Rd, Wu						

			For Stete Registrar	State		and / Dep <i>Ce</i>	artmer	nt of H			-		е) C	122	16
	Dhysisi	210	1. Decedent's Name (First, Middle								2. Date of Di	eath Da		Year	3. Time of	
	Physicia /Medic		Elizabeth D. Jo								March	20		2005	211	8 м
	Examin	er	4a. Facility Name (If not institution	•					r Location o	of Death			c. County			
	F		Regency Park 5. Social Security Number	ASSISTE 6. Sex		ng vrs. last birthday,		nbril	If Under a	24 Hrs.	8 Date of Bi			Arund		or Foreign
	Funeral Director		214-14-8346	1□ M 2☐ F			Months		Hours	Min.	8. Date of Bi	Year	1919		ace (State of try) rylane	
	pu ,		Usual Residence of Decedent												-	
	shov	7	10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Annapolis									10d. In				
25 35 55 75	28a-f	ect	Maryland Anne 10e. Street and Number	Arunder		Alliapo.		p Code				10a C	itizen of V	Vhat Coun		2 No
3 3	3a or	Funeral Director	2598 Twin Land	ling Cove				1401						State		
12/2	death	nera	11. Marital Status	12. Was D	ecedent Ever in Forces?	n U.S. 13.	Was Dece	edent of H	ispanic Orig	gin? (Spe	cify Yes or N Rican, etc.)	0-		e - America		
36	s after , or it	by Fu	1 Never Married 2 Marr	ied 1 ☐ Ye	s 2 ☑ No Give		1 ☐ Yes		Specify:		riidari, etc.)			k, White, e whi		
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment for indiffed all once.	To Be (17. Father's Name (First, Middle, Harry William								(First, Middle iller	e, Maide	n Sumam	e)		
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ei ei	1 and 1 and 1 am 27 3 m 27 ther t		Patricia J. Kran 20a. Method of Disposition	itz/ daug		b. Place of Disp	_		reat .		e Davi	_		e, MD City or To		5
nor	ages nt of I t: if its / or o		1 Burial 2 Cremation		m State	cometery, cre	matory or	other plac		3-22				re, M		
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8760,	within 24 hours after death. within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed to be secured for the Funeral Director. After this certificate has been signed by the attending physician and in pactor. Sompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Deme	sequence of): sequence of): sequence of):	A-				A			13	Interval Bet Onset and (Lean)	Death
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			30. Name and address of period	who completed da	ause death ((Item 23a) (Type	Print)	din	4 P	nk	Orev	pl	Con	Bur	niela	14
	Sta	ite	31. Date filed (Month, Day, Year)	3/2	Restrairs Si	ignature _		1100	10	(/		1	UU			1 2100
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		1	For State Registrar	State of Mai	-	epartment of Certificate of			_	giene Reg. No	4000	12217
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	arylanc Bhow	_	10a. State 10b. County		10c. City, Towr							10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	the Ma 28a-f	Director	WV HAMPS	HIRE	SPRII	NGFIELD 10f. Zip Code				10a. Ci	itizen of What Co	
	h with	al Di	ARNOLD STICKLEY	ROAD		26763				-	J.S.A.	
	tems (Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Decedent of If Yes, specify Co	f Hispanic Jban, Mex	Origin? (Specifican, Puerto Ric	y Yes or No an, etc.)	p-	14. Race - Ame Black, Whi	
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Maryland	should be nd Mental marked c	To	ALVIN HARTLEY	FRAZE				MATILDE	VORH			
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ore,	of Health of Health litem 27 r other tr		20a. Method of Disposition 1 Durial 2 Cremation 3	Domoval from State		Disposition (Name of y, crematory or other p	lace)	Date	ө	20c. L	_ocation - City or	Town, State
Baltimore,	Page tment tent: If		`4 □Donation 5 □ Other (Special	(y)	CUMBERI	LAND CREMA		03/21/	2005	(CUMBERLA	ND, MD
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	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier /	and manner stat		29c Lice	ense num	ber		29d D	ate signed (Mon	th Day Year)
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	5		30. Name and address of person who	completed cause of de		(Type, Print)	/2	Sorralo	Dalus	- 01	MALEN	2005 AND 1156
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05-2253 B.K.S MICHAEL

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Physic	ian		ne (First, Middle, t el Eugen				artment of F			2. Date of Do Month	Day	Year	3. Time of Death
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Funeral Director		5. Social Security N 213-80-4 Usual Residence o	1442	.Sex 7./ 17X2 M 2 □ F	Age (In yrs. Ia	Vee	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di May 03	rth a <i>y, Year)</i> 3 1958	9. Birth	place (State or Foreig intry) PA
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** A M Linda Dunbar Kravitz March 19, 9:15 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Chevy Chase 5100 Dorsett Avenue, #304 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6 Sex **Funeral** Months Days 0472971943 1 □ M 2 🕱 F 61 Yrs. 031-30-5218 Maryland Director Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If them 27 is marked other than "netural", or Items 23e or 28e-1 ehow eny injury or other treumatic event. The Medical Execution remails be notified at once. 1X Yes 2 □ No Chevy Chase Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5100 Dorsett Avenue, #304 20815 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White by 3 Widowed 4 Divorced ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Complet College (1-4or 5+)
5+ Elementary/Secondary (0-12) Social Research Consulting 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Peggy R. Rawls Leslie Wallace Dunbar ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5100 Dorsett Ave., #304, Chevy Chase, MD 20815 Hugh Knox, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ft. Lincoln Crematory 03/27/2005 Brentwood, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of F neral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 endy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Ovarian Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day jo in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy perform 2X No 1 ☐ Yes 2 ☐ No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Deatn Check onl one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home St Residence 6 Other (Specify) 1 ☐ Yes 2X No Ġ P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; After Injury 1 X Natural 5 Pending investigation 1 Yes 2 🗌 No death. 2 Accident d in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 | Homicide Within 24 hours are.
To the Funerel Dir i Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only оде) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 March 24, 2005 D29142 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Boice, MD, 10301 Georgia Avenue, Suite 205, Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 25 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:25 A 27 2005 March Joyce E. Kelly /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Williamsport Homewood Retirement Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 🛛 F West Virginia 62 Aug.18, 1942 235-66-8831 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County worde | ne 23a or 28a-f eho 1 Yes 2 No Mineral Keyser West Virginia Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number HSA 26726 Rt. 5 Box 57 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married 5 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 ₩Widowed 4 □ Divorced "natural" Completed the Madical I 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Day Care Center Owner/Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be i and Mental I Pages 1 and 2 should be Reed Jov Elmer T. Rhodes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Falling Waters, WV 25419 if item 27 i Lorrie Fredlock - Daughter 244 Michigan Drive 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or ance. '4 □Donation 5 ♥Other (Specify)Entombment Potomac Mem. Gardens 03-29-2005 Keyser, West Virginia 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Funeral Service Lights 425 S.Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examiner The law requires that the death certificate be executed for use as the burial-transli attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death Year Month Dav in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 5 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificete Hospitei or Attending Physician: Be 26. Place of Death Check only one director, 25. Was case referred to medical Other: Hospital: 1 ☐ Yes 2 27. Manner of Death 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 his 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification; After Injury Natural Accident 5 Pending investigation 1 🗌 Yes 2 No death. Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification se of death (Item 23a) (Type, Print) noleted 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:56 AM MARCH 2005 Earl William Keller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Hospital pital Hagerstown
7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Washington 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2 ☐ F Months Days Hours Min Yrs. Director 84 Mar. 13, 1921 Pennsylvania 202-07-9824 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it will be recitified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits XXYes 2□No Director Maryland Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21740 USA 216 West Side Avenue Funera Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2√No Specify: Specify ð 3XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Shoe_Manufacturer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank E. Keller Florence I. Dague 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Price - Friend 3518 Coseytown Rd. Greencastle,PA 17225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Manor Cemetery ^¹ 4 □ Donation 5 □ Other (Specify) Mar. 31, 2005 Boonsboro, Maryland 21. Signature of Funeral Service Liger じらからずれる 伊也ffetaillyHome, P.A. 425 S. Conococheague St.Williamsport,MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that let the cause or injury) Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the a 9 Unknown 9 🗆 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 performed page this certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No investigation М 2 Accident the Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who WAHRED 28 HBOUL MO 31. Date filed (Month) Ray 32. Registrar's Signature State

DHMH 17 Rev 1/2001

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, If we would Examinate ust be notified at once.		19a. Informant's Nar Nancy Lea					_				<i>l Route Numb</i> erstown				ode)
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Sici	ttend death stor: /	lcat	2 Accident 3 Suicide	investigati	be an Plan	a of Injury -	At home, farm,			162 2	-	28f. Location (Street ar	d Number or	Rural F	loute Number
> N	l or Attenc after death Director: I in by the	Certification:	4 Homicide	determine	build	ing, etc. (St	pecify)	street, racto	ry, omce			City or To	wn, State)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)	1 Certifying F	Physician: To the aminer: On the b	e best of my basis of examiner stated.	knowledge, de mination and/or	ath occurred investigation	d at the tir	ne, date a pinion, de	and place, a	and due to the ed at the time,	cause(s) and manner d place, and o	as state	ed. e cause(s)
	To the within 2 To the comple	Mec		title of certifier	- City mai			29	c. Licens			,	29d. Da	te signed (Me	onth. Da	y, Year)
	15.		1	ine "	m				0		5035	36	0	3 128	5/0	5
	2+1		30. Name and addre		o completed cau		(Item 23a) (Typ	e, Print)	126	1	Cal Llago	Truos Lustrus	1	mo	21	740
	Sta		31. Date filed (Mont	AR 30	2005 32.1	legistrar's S	Signature	back	,		7 8		1			
8.	Registi	OD1	1,	INIC O D	2000	ecca-	N. P.	,,								

			1 - For State Registrar	State of Mary		artmen rtificat			d Mental F	lygie:	6 1111	5 1	2223
	Physic	ian	Decedent's Name (First, Middle, Last,						2. Date of Month		Day Ye	3. T	ime of Death
4	/Medi		Walter Burg		nk				March		2005		:45 a [™]
A.	Exami	ner	4a. Fecility Name (If not institution, give	street and number)				Location of D	eath		4c. County of I		
			14557 Sandy Lane	12.00		Ede					Some		
	Funeral Director		5. Social Security Number 6. Sec. 12	7. Age (In	n yrs. last birthday) Yrs.	If Under Months	Days	If Under 24 I Hours A	Ain. (Month,	Birth Day, Ye	ar) 9.	Birthplace (S Country)	State or Foreign
			Usual Residence of Decedent	/.	Z 110.				10/13	3/19.	32	Maryla	nd
	yland yland		10a. State 10b. County	10	c. City, Town or Lo	ocation						10d. Ins	ide City Limits
	Mar P-f st	ţ	Maryland Somers	set	Eden							1 [Yes 2 No
	h the	Funeral Director	10e. Street and Number			10f. Zip	Code			10g.	Citizen of Wha	t Country?	
	th wit	a D	14557 Sandy Lane			21	1822				USA		
	deal	ner		12. Was Decedent Ever Armed Forces?	in U.S. 13.			spanic Origin?	(Specify Yes or uerto Rican, etc.)	No-	14. Race - /	American Indi	an,
9	or its	F	1 ☐ Never Married 2X Married	1 X Yes 2 □ No		1 ☐ Yes :		Specify:	Jeno Hican, etc.)			Vhite, etc.	
8	72 hours after death with the Maryland natural", or items 23e or 28e-f show aloue Examiner, was be notified at	d by	3 Widowed 4 Divorced	Year or Dates:A1]	rForce	12 103					Specify:	white	
215-0036	"nat	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece (Give	dent's Usua kind of wor	al Occupa rk done d	ition furing most of)	working	16b	Kind of Busine	ess/Industry	
12	within 3 ene. than "	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)						_			
d 21	filed withing Hygiene. Hygiene. other than than out, the M		17. Father's Name (First, Middle, Last)	-	Irans	sporta	atior		Name (First, Midd		ers Hea	d Hosp	ital
an	Mental I Mental I arkad ol	o Be	Norman Lank					Ethel		know			
Maryland	2 should and Men Is marka aumetic	²	19a. Informant's Name/Relationship (Ty	oe. Print)	19b. Maili	no Address	(Street a		Rural Route Nun			to Zin Codol	
Σ	~ ~ ~ ~		Pauline K. Lank/wi	•					den, MD			e, <i>zip</i> code)	
Ĉ,	s 1 and of Health itam 27 other tra		20a. Method of Disposition		Ob. Place of Dispo	sition (Nan	na of	1	Date		Location - City	or Town, Sta	ate
9	4 0 ••• ••		1 XBurial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)		Wicomico	Memo:	rial rial		20 /05				
altimore,	Fig. 1		2. Signature of Funeral Service License		Park	2. Name an	d Addres		30/05		lisbury		
ñ	Departing Important any r		H Children	CE	SP 5	IOLION	vay F	unerál	Home Pr	ofes	sional	ASSOC	iation
			23a. Part1. Enter the disease, or compli	nions that caused the		er the mode	e of dying	, such as card	diac or respiratory	arrest,	/, PID Z	Appro	ximate
J.	Physician		Immediate Cause (Final	e cause on each line.	an								al Between and Death
100	/Medical		disease or condition resulting in death)	Due to (or as a go	nsequence of):							72	yrs.
	Examiner		Constant to the transmission of the	C	VA							47	1
	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or injury	Due to (or as a co	nsequence of):							>2	
	ecute ind trans	Examiner	that initiated events cresulting in death) Last		OPD							16	the
50,	be executed sician and burial-transit		lessitting in death) Last	Due to (or as a cor	Control Inches							77	yus.
8760	ate hys the	Physician/Medical	0		ell	<i></i>						- ' -	po ,
9 x	eath certific attending p for use as	/Me	IF FEMALE:	3c. If yes, outcome of pr	'eanancy								
Вох	atten for u	clan	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	Ectopic pre				l,	23d. Date of Month	delivery Day	Year
o.	that the de led by the de detached	ıysl	1 Yes 2 No 9 Unknown	9□ Unknown	ordean 3L	J Other (Spe	BCIIY)						
Δ.	The law requires that ite has been signed b age 2 should be deta		Part II. Other significant conditions con	tributing to death but no	t resulting in the u	nderlying ca	ause givei	n in Part I.	23e. Dio	tobacce	use contribute	e to the cause	e of death?
of Vital Records,	n sign	d by	Ostropass	in					1 [] Yes	2 No 3	Probably	4 Unknown
S	w requ	Completed							24a. Wa	s an	24b Were	autonsy find	lings available
Re	The lav ate has page 2	E C							aut per	opsy formed?	prior death	to completion?	of cause of
ta		0	25. Was case referred to medical					OS Diago of D	1 Yes		40 1 □ Y	'es 2□ No	
<u>></u>	Physician: this certific ral director,	OB	examiner?	ospital:	2 ER/Outpatien	t 3 🗆 DQ	Other		eath Check only		6 Other (S	nacihi)	
		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time of		Bc. Injury Work		28d. Describe			респу)	
0	Attanding Ph r death. ector: After th by the funeral	atlo	1 Natural 5 ☐ Pending investigation	(Month, Day 198	ar) Injury	М		? es 2 ☐ No					
Division	after death	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str	eet, factory,	, office				and Number or	Rural Route	Number,
	itel or A rs after al Dire ed in by	Cer		building, etc. (of) do((y)				City or T	JWII, SEE	110)		
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier / Certifying Phys (Check only one)	cian: To the best of my er: On the basis of exar and manner stated.	knowledge, death mination and/or inv	occurred a restigation,	it the time in my opi	e, date and pla nion, death oc	ce, and due to the courred at the time	e cause e, date a	s) and manner nd place, and c	as stated. lue to the cau	ıse(s)
	To ti Withii To ti comp	Ň	29b. Signature and title of certifier			29c.	License	number		29d. C	ate signed (Mo	onth, Day, Ye	ar)
)	2 MD		homa	no		1	HO	613	27	:	31781	کن	
<	11/4		30. Name and address of person who con	npleted cause of death	(Item 23a) (Type,						1-31		
	1011		Elleda Ziemer	100 P	ower St.	, Sal	isbu	ry, MD	21804	4	10-543-	2060	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 9 200	100 P 32. Agistrar's S	ignature	all					8333	10000000	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Julius Louis LEBOW <u>4:</u>30 March 25, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□F Months Director 1915 Maryland 213-05-7396 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a State 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Silver Spring Maryland Montgomery Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 20903 United States 8500 New Hampshire Avenue #341 239 death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Salesman Janitorial Supplies 12 Hygie other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 Is marked oth any injury or other traumatic event ones. Be Isaac Lebow Sarah Weiner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20903 19a. Informant's Name/Relationship (Type, Print) 8500 New Hampshire Ave., #341, Silver Spring, MD Frieda Lebow, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 03/28705 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Isaac Adath Israel Cong. Cem. Baltimore, MD 21. Signature of Funeral Service Licens is 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part Level the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medlcal use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à ils certificate has been signe director, page 2 should be 1 Yes 2 No 3 Probably 4 ∑Unknown Liver Failure, Renal Failure Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours a 29a, Certifier 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier aeanno 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Ave. Takoma Park, MD Deanna White, M.D., 31. Date filed (Month, Day, Year) 28 MAR Registrar

State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death Rea. No: 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 4:24 PM L-abaskind 24 1.5.25 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Heren Home Francos If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min 1□M 2ŪF Yrs 08/25/1914 578-03-9623 90 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic avent, the M-citcel Examinar must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Montgomery Rockville 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 6105 Montrose Road 20852 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No SpecifeWhite Specify: If Yes, Give Year or Dates: þ 3 XWidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mayer Stuck Lena Apter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6878 Happy Heart, Columbia, MD 21045 Alvin Liebeskind/son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition PETACH TIKVAH CEMETERY 3/28/2005 1 Bunal 2 Cremation 3 Removal from State 4-Bonation 5 ☐ Other (Specify) ROSEDALE, MARYLAND 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction, 1091 Rockville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) incumorit /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Fa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the burial-transit The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) the 9☐ Unknown 9 Unknown s been signed by to should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Blahemers Demand Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an B-Comic this certificate has funeral director, page 2 autopsy performed 1 Yes 2 No 1 Yes Pulmonary Discuss Chans 0/027 or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death After Injury 1-Natural 5 Pending 2 No 1 Tyes death. investigation filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20057884 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1801 3 Jaff erson 10:52 31. Date filed (Month, Day, Year) MAR 28 32 Registrar's Signature State 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For Stata Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Sima Markowit Z 2005 2:45 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville greater Washington Maryland coren Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Montgonen Brthplace (State or Foreign
Country) 6.Sex (2 ☐ F **Funeral** 5. Social Security Number 7. Age (In yrs. last Birthday) 91 22, Director 050-14-2677 ISRAEL Usual Residence of Decedent with the Maryland other traumatic event, the Medical Exercher must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director MARYLAND MONTGOMERY ROCKVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygien en atturer, or Items 23a any injury or other traumatic event, Item Medical Expenses 23a 200. 6105 MONTROSE ROAD 20852 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 No Specify: þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ TEACHER HIGH SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AVRAHAM COHEN CHANA MARKOWITZ ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVRAM BAR-COHEN/SON 4767 BERKELEY TERRACE, NW, WASHINGTON, D.C. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ERETZ HA CHAIM CEMTRY 3/25/2005 BET SHEMSH, ISRAEL 21. Signature of Funeral Service Licenses DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. Cottlemeger 1170 ROCKVILLE PIKE, RUCKVILLE, MARYLAND 20852 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 weeks Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The taw requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): M ですた (カル) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) the a 9☐ Unknown 9 Unknown as been signed by to 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Carcinoma 24a. Was an autopsy performed? Yes 2 No certificate 2 No 1 🗌 Yes 1 Yes or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pendina 1 ☐ Yes 2 ☐ No investigation М 2 Accident within 24 hours after death To the Funerel Director: filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier mp 37464 March 22, 2005

Lot 21 Muntose Road Rockville, Manyland

Les Sinature and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
32. R 32 Registrar's Signature State 5 2005 Registrar

DHMH 17 Rev 1/2001

			1- State of Maryland / Per Dr., G842	Dep Ce	artment of Health and M 726705dhb rtificate of Death	Лental Нус	giene Reg. No 2 0	5 12227
	Physic	an	1. Decedent's Name (First, Middle, Last) Rose Marie Mullin			2. Date of Dea Month March		3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 10122 Woodsboro Road		4b. City, Town, or Location of Death Woodsboro	L	4c. County of E	Death
	Funeral Director		5. Social Security Number 212-58-9995 6. Sex 1 M 2 XF 7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Aug. 14	y, Year) 9.	Birthplace (State or Foreign Country) MD
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow MD Frederick Wood					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the 3a or 28a	Il Director	10e. Street and Number 10122 Woodsboro Road		10f. Zip Code 21798		10g. Citizen of What	t Country?
980	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Madical Exercites: wat be rotified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto To Yes 2 XNo Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
Maryland 21215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event. Ita Modical Exercitivet: and be reciffed at	Completed by	(Specify only highest grade completed) Elementary/Secondary (0.12) College (1.4or 5.4)	(Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) Litorial duties	ing	16b. Kind of Busine educati	ess/Industry
/land		To Be C	17. Father's Name (First, Middle, Last) Clarence Franklin Mullin				Maiden Sumame) erine Boy	wers
	nd 2 shallth and 27 is m		Mary A. Parsons sister 1	012	ng Address (Street and Number or Run 2 Woodsboro Rd	.Woodsl	r, City or Town, Stat OOCO, MD	e, Zip Code) 21798
Baltimore,	0 0		1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	l'é l	sition (Name of natory or other place) March Rose Hill 200	5	20c. Location - City Clear Sp	pring MD
Bal	permit. Pag Department Important: I any injury o		23a. Perf.1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	22 I	Name and Address of Facility Donald Edwin Th P.O.BOX 310 Cle	ompson ar Spr	Funeral	Home,Inc
	Physician /Medical Examiner		23a. Part. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	riti		or respiratory arr	lisease	Approximate Interval Between Onset and Peath
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to trimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Cues to (or as a consequence c. Due to (or as a consequence c.)					
.O. Box 6	the death certifi the attending proched for use as	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year
rds, P	sign d be	by P	Part II. Other significant conditions contributing to death but not resulting i	n the ur	iderlying cause given in Part I.	23e. Did tob		to the cause of death? Probably 4 Unknown
il Records,	The law ate has b page 2 s	Completed	'			24a. Was a autops perform	y prior t ned? death	autopsy findings available to completion of cause of ?
Jivision of Vitali	Attanding Physician: Th r death. actor: After this certificate by the funeral director, pag	ertification: To Be	1. Actival 5 Pending (Month, Day Year) I investigation	Time of Injury	28c. Injury at Work? M 1 Yes 2 No	me Seside 28d. Describe ho	ence 6 □Other (S	
QX Q	or of in in in in in in in in in in in in in	0	4 Homicide determined 286. Place of injury - At nome, to building, etc. (Specify)			City or Town	n, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funaral I completely filled	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated. 29b. Signature and title of certifier	d/or inv	estigation, in my opinion, death occurr	ed at the time, da	ause(s) and manner ate and place, and d 9d. Date signed (Mo	ue to the cause(s)
0	12		30. Name and add ess of person who completed cause of death (Item 23a)	(Type 1	D0031058		03/30/200	5
100	Sta Registr		Gene F. Ashe, MD Woodsboro Medica 31. Date filed (Month, Day, Year) 32r Registrar's Signature	1 C	enter 10200 Coppe	ermine R	d Woodsb	oro Md 21798
	riegisti	A1.	MAR 3 0 2005	1				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla	-	artment of			ene g. No. 005	12228
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, La. AN CY 4a. Facility Name (If not institution give	NNF	Mac 1E Lars	Don 4b. City, Town	ald o, or Location of Death	2. Date of Death Month		3. Time of Death
	Funeral Director		5. Social Security Number 6. S		s. last birthday)	If Under 1 Yes Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day) 03/03/1	9. Birthp Court	lace (State or Foreign try)
	death with the Maryland rms 23a or 28a-f show I must be notified at	Director	10a. State 10b. County MD Worces		cean C				1	0d. Inside City Limits 1 ☐ Yes 2 X No
	with th	I Dire	10e. Street and Number 9641 Golf Course	a Poad		10f. Zip Code		10	g. Citizen of What Coun	try?
5-0036	or ite	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Amed Forces? 1 Yes 3 No If Yes, Give Year or Dates:	If		f Hispanic Origin? (Suban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	etc.
215-(Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Deced (Give I life. L	ent's Usual Occ kind of work dor OO NOT use reti	cupation ne during most of wor. ired)	king	6b. Kind of Business/Inc	lustry
12121	led within ygiene. har than "	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Dryv	vall Fin			Constructi	on
Maryland	s 1 and 2 should be filed within 'f Health and Mental Hygiene. item 27 Is marked othar than "lothar traumatic event, If a Mo	To Be	17. Father's Name (First, Middle, Last) Harold Snyder 19a. Informant's Name/Relationship (1)	Type Print	10h Mailia	A d d (CA	Marian	Armstron	ng	
	and 2 s lealth an m 27 ls i		Randall G. MacDo			-			City or Town, State, Zip City, MD 2	•
nore	ages 1 ent of He it: If itan y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Romoval from State		atory or other p			oc. Location - City or To	
Baltimore	permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar tr QDG9.		21. Signature of Fundal Service Licen	,	22.	Name and Add		ırbage Fu	uneral Home	
	Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, or hear/failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the deaderne cause on each line. a. Due to (or as a conse	ath. Do not ente		ying, such as cardiac		st,	Approximate Interval Between Onset and Death
8760,	ate be executed shysician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse						
.O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 2No 9 □ Unknown	d	al death 3 🔲	Ectopic pregnan Other (specify)	icy		23d. Date of deliver	ry Day Year
rds, P	w requires tha been signed should be del	by	Part II, Other significant conditions of	ontributing to death but not re	sulting in the un	derlying cause o	given in Part I,	23e. Did toba 1 □ Yes	cco use contribute to the	e cause of death?
al Records,		Completed						24a. Was an autopsy performe	prior to com	psy findings available apletion of cause of
Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?	Hospital:	☐ ER/Outpatient	2C DOA 0		h (Check only one)	0.504/0.11	
	Attanding Phys r death. ector: After this by the funeral dii		27. Magner of Death 12 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj W	4 □ Nursing Ho ury at ork? □ Yes 2 □ No	28d. Describe how	ce 6 Other (Specify, rinjury occurred	
Division	afte Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	et, factory, office	Ð	28f. Location (Stre- City or Town,	et and Number or Rural State)	Route Number,
	To the Hospital or within 24 hours afte mythin 24 hours afte To the Funeral Direct Completely filled in it	Medical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	rsicien: To the best of my kn iner: On the basis of examination and manner stated.	owledge, death ation and/or inve	occurred at the estigation, in my	time, date and place, opinion, death occur	and due to the caused at the time, date	se(s) and manner as sta e and place, and due to	ited. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	Alm	\bigcirc	Α.	26278	0	I. Date signed (Month, E	
H	, 2		30. Name and address of person who of DAND COUNTY, W	ompleted duse of death (Ite	m 23a) (Type, P	PO 1	Box 1733	Sali	3-25-	21862
	Sta Registr	170	31. Date filed (Month, Day, Year) MAR 2 8 20	32. Degistrar's Sign	avere do	ule	26278 Box1733	3.770	7 1000	

hysician /Medical	ľ	. Decedent's Name (First, Middle, La					2. Date of De	Day	Year	3. Time of Death
	-	DOLORES ROSE					March	26,	2005	08:40 [™]
xaminer	4	a. Facility Name (If not institution, given Hartley Hall		Home	4b. City, Town, or Lo				County of Death	
eral	1		Sex 7. Ag	e (In yrs. last birthd	Months Days F	Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb. 1	rth ay, Year)	9. Birth	place (State or Foreign
or		05-34-9878	10 W 2021	93 Yrs			Feb. 1	2, 19	912 Penr	sýlvania
		0a. State 10b. County		10c. City, Town o				_		10d. tnside City Limits
ctor		MD Worcester		Pocomoke						1 Yes 2 No
Completed by Funeral Director	1	^{0e. Street and Number} 1006 Market Stree	et		10f. Zip Code 21851			10g. Citiz	zen of What Cou SA	intry?
Inera	1	1. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Spec	cify Yes or No)- I	14. Race - Amen Btack, White	
y F.		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Tes 2 ft tf Yes, Give Year or Dates:	V 0		Specify:				ite
ted t		15. Decedent's E (Specify only highest gr.	I	16a. De	cedent's Usual Occupation	n , , ,		16b. Kir	nd of Business/Ir	
nple	-	Elementary/Secondary (0-12)	College (1-4or 5	i+)	ive kind of work done during. DO NOT use retired)	ng most of workin	g			
S	1	I Z 7. Father's Name (First, Middle, Last		Cons	ultant	. Mother's Name	/Eiret Middle	Brid		
To Be		Vincent J. Scale	•			Theresa			,	
		9a. Informant's Name/Relationship			ailing Address (Street and			_		
	-	atherine C. Huey, Oa. Method of Disposition	daugnter		Winter Quar sposition (Name of	ters Dr.			cation - City or T	
Annual of China traditions avail. It is not be completed by Funeral Director	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specie		cemetery, o	rematory or other place) Heart Cem.		2005		nette,	
9	2	1. Signature of Funeral Service Lice	-		22. Name and Address o				•	
any II		Michael ADa	an		103 Linden A	ve., Poc	comoke	City	, MD 21	851
he burlal-transit		Gequentially list conditions, any, leading to immediate ausa. Entar Under in grause (Disease or injury nat initiated events esulting in death) Last	c	a consequence of):						
la E			d							
as the bu	2	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	4□Pregnant at 9□Unknown	2 Fetat death time of death	3 □Ectopic pregnancy 5 □ Other (specify)		er:	2	3d. Date of deliv Month	ery Day Year
by Physician/Medical	2	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetat death time of death	5 Other (specify)	n Part I.			Month se contribute to t	
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be detached for use as the but by Physician/Medical	P -	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions of the con	1 Live birth 4 Pregnant at 9 Unknown contributing to death be	2 ☐ Fetal death time of death under the conditions of the conditi	5 Other (specify)	i. Place of Death	24a. Was autor performed to the control of the cont	obacco us Yes 2 on an osy 2 one)	Month se contribute to t No 3 □ Prot 24b. Were auto prior to co death? 1 □ Yes	he cause of death? pably 4 □Unknown psy findings available impletion of cause of 2 □ No
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by Physician/Medical	P	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions of the past 12 months? 5. Was case referred to medical examiner? 7. Manney of Death 1 Matural 5 Pending 2 Accident investigation	Hospital: 28a. Date of Injuu (Month, Day)	2 Fetal death time of death time of death ut not resulting in the	o underlying cause given in 26 itent 3 DOA Other. 28c. Injury at Work?	i. Place of Death ,	24a. Was autoperformer 1 Yes	obacco us Yes 2 5 an an posy Immed? 2 5 No	Month se coptribute to t No 3 Prot prior to co death? 1 Yes	he cause of death? pably 4 □Unknown psy findings available impletion of cause of 2 □ No
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led in by the funeral director, page 2 should be detached for use as the bu Certification; To Be Completed by Physician/Medical	P - 2	3b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Injur (Month, Day) 28e. Place of Injur building, etc.	2 Fetal death time of death time of death time of death ut not resulting in the ut not resulting in the 2 ER/Outpa 28b. Time Injury - At home, farm, c. (Specify)	Other (specify) a underlying cause given in 26 ient 3 DOA Other. a of 28c. Injury at Work? M 1 Yes	i. Place of Death 4 Vursing Hom 28 2 □ No 28	24a. Was auto perfect 1 Yes (Check only ce 5 Resided. Describe land due to the	obacco us Yes 2 5 an osy rmed? 2 15 No one) dence 6 how injury Sireet and	Month se contribute to t No 3 Prot 24b. Were auto prior to co death? 1 Yes Other (Special occurred	Day Year the cause of death? pably 4 Unknown posy findings available impletion of cause of 2 No fy)
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			For State Registrar	State of Ma	aryland /		artment o				iene	005	12230
	Physici	an	Decedent's Name (First, Middle		1 5	1		2.1		Date of Deat Month	h Day	Year	3. Time of Death
	/Medic	al	Joseph	Edward	d Bro	oadus	MCD 4b. City, Tow	onald	an of Dooth	03_	16	County of Death	1530 M
	Examin	er	4a. Facility Name (If not institution	O O L L	snita	1	46. City, 10w	1 hoc	on or Death	ĺ	0	110GA	nvl
	Funeral		5. Social Security Number		e (In yrs. last bi	rthday)	If Under 1 Ye		der 24 Hrs.	8. Date of Birth (Month, Day,	Voar)	9. Birthe	place (State or Foreign
	Director		220-26-9848	1⊠M 2□F 7	4	Yrs.	Months Da	ys Hour		12/01/193		Mary 1	
	A.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Lo	cation					1	0d. Inside City Limits
	Maryl -f sho	ţ	MD Alle	gany	Cum	berla	and						1X Yes 2 No
	n the	Director	10e. Street and Number				10f. Zip Coo	ө		10	0g. Citiz	en of What Cour	ntry?
	th wit		418 Walnut	Street			2	1502				USA	
	er dea	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13.	Was Decedent f Yes, specify (of Hispanic Juban, Mexi	Origin? (Specican, Puerto F	cify Yes or No- Rican, etc.)	1	 Race - Americ Black, White, 	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 ∑Yes 2 ☐ N If Yes, Give Year or Dates:	№1951- 1955		1 ☐ Yes 2 🛱	No Spec	ify:			Specify:	h: to
8	n 72 hours after death with the Maryland "natural", or Itema 23a or 28a-f show edical Examinational be notified at		15. Decedent	's Education			ient's Usual Oc				16b. Kin	d of Business/In	hite dustry
215		Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	kind of work do DO NOT use re	ne during n tired)	nost of workin	g			
21	77	S	12			Ele	ectrician					te Glass	
and	be d al	Be	17. Father's Name (First, Middle,		M-	Domo	1.1			(First, Middle, N	Maiden S	Smith	
Maryland 21215-0036	2 should be and Mental I is marked o aumatic eve	ဥ	Alfred 19a. Informant's Name/Relationsl	Quay		Dona b. Mailir		1	uth mber or Rurai	Route Number.	City or	Town, State, Zip	Code)
	d 2 th a tra		Anita L. McDonald				•			land, Mary			
J.	es 1 an of Heel fitem 2 r other	9	20a. Method of Disposition 1	2 Demoved from State	20b. Place o	of Dispo	sition (Name o	place)	Di	ate	20c. Loc	ation - City or To	own, State
Ë	Pages ment of ant: if it ury or o		` 4 ☐ Donation _5 ☐ Other (S)	oecify)	Sunset		orial Par		03/19/2			rland, MD	
Baltimore,	permit. Pag Department Important: i any injury o once.		21. Signature of Fundral Service	Licensee adden	ne	22						ral Home, yland 21	
			23a. Pan1. Enter the disease, or shock, or heart failure. List	anhy and anuca on each lic	30								Approximate Interval Between
	Physician	0.7	Immediate Cause (Final disease or condition resulting in death)	_a. DEC	MPS	NS	4TED	CON	G-EST.	IVE H	EAR	TFALL	Onset and Death
	/Medical Examiner			Due to (or as	a consequence	of):							
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Oue to (or as	a consaguanca	rof):							
	cuted	Examine	that initiated events	с.									
Ö,	e exercian ar urial-t	EX	resulting in death) Last	Due to (or as	a consequence	of):							
8760,	cate be executed physician and the burial-transit	dlca		d									
9 X	eath certific ettending p I for use as I	Physiclan/Medical	IF FEMALE:	23c. If yes, outcome	of pregnancy	-					2	3d. Date of delive	arv
Box	death e etter d for u	iclar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregna Other (specify					Month	Day Year
P.0	by the destached	hys	9 Unknown	9∐ Unknown									
	res the igned be del	by	Part II. Other significant condition	ons contributing to death b	ut not resulting	in the u	nderlying cause	given in Pa	art I.				ne cause of death?
ord	w requir been s should	eted									s 2 🗆		
Records,	The lar	Completed								24a. Was ar autops perform 1 Yes 2	y ned?	prior to condeath?	psy findings available mpletion of cause of 2 No
Vital	ician: 1 certificel rector, p	Be	25. Was case referred to medical examiner?						ace of Death	(Check only on	9)		
of \	Phys this al di	ဥ	1 ☐ Yes 2 Ø No 27. Manner of Death	Hospital: 1 ⊿Inpatie		utpatier Time of	I DOM	Other: 4		ne 5 ☐ Reside 8d. Describe ho		Other (Specify	y)
OU		tlon	1 ØNatural 5 ☐ Pendin 2 ☐ Accident investig	g (Month, Da)		Injury		Work? I∐Yes 2	_	ou. Describe no	W IIIJUIY	occurred	
Division	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	Certification;	3 Suicide 6 Could r 4 Homicide determ	not be 300 Blace of Init	ury - At home, f c. (Specify)	arm, str	eet, factory, off	се	2	8f. Location (St. City or Town		Number or Rura	l Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical C	29a. Certifier (Check only one) 1 Certifyin 2 Medical	g Physician: To the best Examiner: On the basis of and manner sta	examination a	je, deat nd/or in	n occurred at the	e time, date ny opinion, (and place, a death occurre	nd due to the ca	use(s) a ate and	and manner as si place, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certified	/			29c. Lic	ense numb	өг			signed (Month,	
	TIVA			-07V			Dá	1337	7	1	Mas	ch 17,7	1003
_	nes		30. Name and address of person OR · OAMAR	ZAMAN 1	025 F	(Type,	+ Ave	. Cu	mber	land.	ME	2150	32
	State Registrar MAR 18 2005 32. Registrar's Signature												

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of M	Marylar		artment rtificate			and Mental Hy	giene () (15	12232
	Physici	an	1. Decedent's Name (First, Middle John Chi	e, Last) ristopher	M	eixner				2. Date of De Month	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution			EIVHEL	4b. City, To	own, or L	ocation o	Marc	4c. County	2005 of Death	2:25 AM
	LXaiiii	101	Union Memorial	Hospital			Balt:				Non	e	
	Funeral		5. Social Security Number 216-88-2534	6. Sex 7. A 1 → M 2 □ F	Age (In yrs. 28	last birthday) Yrs.	If Under 1 Months	Year Days	If Under:	Min (Month D	th ay, Year) 1976	Countr	ace (State or Foreign Y)
	Director		Usual Residence of Decedent	A	20					Берг.	1970	remisy	утуанта
	72 hours after death with the Maryland natural; or items 23e or 28e-f show deal Exantiner must be notified at	_	10a. State 10b. County			ty, Town or Lo						10	d. Inside City Limits
	he Ma	Funeral Director	Maryland Baltin	nore	Whi	ite Mar		Na. ala			10= Cities= of 1	Affras Causas	1 ☐ Yes 2 XNo
	with t	Ö	10e. Street and Number 8108 Ridgetown	n Drive			10f. Zip C	∞œ 1162			10g. Citizen of \		ry ?
	ms 23	Jera	11. Marital Status	12. Was Deceder	nt Ever in U	J.S. 13.				gin? (Specify Yes or No , Puerto Rican, etc.)		e - America	
98	or ite	y Fui	1 Never Married 2 ☐ Marri	If Yes, Give	¶ No		ires, specii 1 ∐ Yes 2 1		Specify:	, rueno nican, etc.)	Specifi	ck, White, et v: Wh j	_
215-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates t's Education	s:	16a Dece	dent's Usual	Occupat	ion		16b. Kind of B		istov
215	within 72 ene. than "na	Completed	(Specify only highe. Elementary/Secondary (0-12)	st grade completed) College (1-4d	r 5+)	(Give	kind of work DO NOT use	done du	iring mos	of working	100.14.10.01.01	2011/03/04/11/04	23(1)
2	fited within Hygiene. other than	Com		5+		At	torne				Law		
Maryland	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Departiment of Health and Mental Hygiene. Impurtent: if item 27 is marked other than "natural", or items 23e or 28e-f show any njury or other traumatic event, the Madical Experiment must be notified at once.	To Be	17. Father's Name (First, Middle, John	Last) S teven	Ma	eixner			18. Mothe	r's Name (First, Middle Donna	, Maiden Suman Athe	•	
IZ	should be tind Mental I	٩	19a. Informant's Name/Relations		110	-	na Address (Street ar	nd Numbe	er or Rural Route Numb			Code)
	alth ar 27 is or trau		Donna Athey/ Mo			0	11fros			ettysburg,	00007 - 686608		
Baltimore,	of Hear		20a. Method of Disposition 1 Surial 2 Cremation		ie (Place of Dispo cemetery, crer	sition (Name natory or oth	of er place,)	Date	20c. Location -		n, State
ij	Pag tment tent: i		' 4 ☐ Donation 5 ☐ Other (S	pecify)	B1t	ıe Ridg				3/29/2005	Thurmon	_	~.
Bal	permit. Pages Department of I Importent: If ite any injury or of once.		21. Signature of Funeral Service	No		10	4 E. N	lain	Str	Stauffer E et, Thurmo	nt, MD	_	PA
8760,	Certificate be executed with the purishment of t	sal Examiner	23a. In 11.—Int in the disea or how in eart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Endo Due to (or a b Po \$5/b) Due to (or a c Po\$5/b)	cavd as a consec 10 /	uence of): v tove quence of): ptir ew		alve		cardiac or respiratory <i>a</i>	rrest,	1	Approximate interval Batween Onset and Death 3 Weeks
9	intificate ing phys as the	Medi	IF FEMALE:					_					
P.O. Box	death e atter	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	2 Feta	aldeath 3	Ectopic prec Other (spec					te of delivery inth D	y Day Year
	Se us	þ	Part II. Other significant condition	ons contributing to death	but not res	sulting in the u	nderlying cau	ise giver	n in Part I.	23e. Did 1	obacco use cont		cause of death?
Records,	law requir as been si 2 should t	Completed								24a. Was		Were autop:	sy findings available
Re	The la	mo								auto	ormed?	doath?	pletion of cause of
Vital	ilcien: The lav certificate has rector, page 2	Be	25. Was case referred to medica examiner?	1. 1. 1. 1. 1. 1.						of Death (Check only	one)		
of	Physicien: this certific ral director,	- To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 XInpa		ER/Outpatier		_	4 🗆 Nu	rsing Home 5 Resi	dence 6 Oth		
O	Attending F r death. ector: After by the funera	tlon	1 Natural 5 Pendir 2 Accident investi		Day Year)	Injury	M	o. Injury a Work? 1 ∐ Ye	5" es 2 🗆 1		now injury coodin	ou	
Division	or Attendi after death. Director: A in by the fu	rtifica	3 Suicide 6 Could 4 Homicide determ	ised 286. Place of	njury - At h etc. (Specia	ome, farm, str fy)	eet, factory,	office	_	28f. Location (City or To	Street and Numb wn, State)	er or Rural i	Route Number,
J	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely illed in by the funeral director.	Medical Certification:		ng Physician: To the be Examiner: On the basis and manner	of examina								
	To th withir To th compl	Me	29b. Signature and title of certifie	r	. ^		29c.	License	number	2:11	29d. Date signer	d (Month, D	ay, Year)
			Herengen	amun N	11)		A	121	(38°	146E+	March	24	2005
	9		30. Name and address of person	who completed cause o	f death (Iter	m 23a) (Type,	Print)	01.	1	Parkway	8.14	11.10	21218
	Sta		31. Date filed (Month Pau Prem)	9 2005 32. F	strar's Signa	ature	Locale	e 151	cy	luruway	balls	MIN	21010
	Regist	aľ			A COLUMN								

		_	1 - For State Registrar	State of N	Maryland / De	epartmei Certifica				ental Hy	/giene,	2005	12233
	Physici	an	1. Decedent's Name (First, Middle, La	st)						2. Date of Do	eath Day	Year	3. Time of Death
	/Medi		Marshall V. Moore			,			1	larch	27,	2005	11:51 A ^M
	Examir	ner	4a. Facility Name (If not institution, giv					r Location of	of Death		4c.	County of Deat	h
			1418 Carpenters F 5. Social Security Number 6. S		d Age (In yrs. last birthi		yvil. r 1 Year	le If Under:	24 Hre	0 0-110		cil	
	Funeral Director			M 2□F	49 0 (III yrs. last birtill 69 Yr	Months		Hours	Min.	8. Date of Bi (Month, D	ay, Year)	Co	hplace (State or Foreign untry)
			Usual Residence of Decedent		09				<u></u>	ec. 3	, 1935	Mary	<u>rand</u>
	rylan how		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Ba-f s	cto	Maryland Cecil		Perryvi1	le							1 ☐ Yes 2 ☐ No
	vith th	Director	10e. Street and Number				p Code				10g. Citiz	en of What Co	untry?
	s 23g	Fra	1418 Carpenters P	oint Road		219		1	1-1-0 (0	- '/- \/ 1		ed Stat	
4.0	fer de	Funeral	11. Marital Status 1 ☐ Never Married 2X Married	Armed Force	s?	13. Was Dece If Yes, spe	ecify Cuba	in, Mexican	n, Puerto F	Rican, etc.)	0-	 Race - Amer Black, White 	
036	urs at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date:		1 🗆 Yes	2₩ No	Specify:				Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show is Medical Evaril serviset be rotified at	Completed	15. Decedent's E			ecedent's Usi Give kind of w			et of workin	2	16b. Kir	nd of Business/l	Industry
21	ithin	nple	Elementary/Secondary (0-12)	College (1-4c	- 1	ife. DO NOT	ise retired	d)	N OF WORKIN	9			
121	lled w lygier her ti		12 17. Father's Name (First, Middle, Last,	1	Li	neman		10 14-45-		/Pilosa Adistria		ctrical	
Maryland	nould be filed withir I Mental Hygiene. narked other than natic event, I was Na	Be								(First, Middle		Sumame)	
Z	2 should I and Meni is marker sumatic	10	Marshall V. Moore	-	19h A	Aailing Addres				Meride		Town, State, Z	in Code)
N S	0 0 0 0		Susan Moore/Wife	.,,,,,									land 21903
ē,	s 1 and 3 f Health item 27 other tra		20a. Method of Disposition		20b. Place of D	isposition (Na	me of		Da	ate		cation - City or	
Ë	95 = 5		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif		MOLUIT	ast Me metery		ist Ma	arch 200	30,	Month	. Foot	Maryland
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Lice	See		22. Name a		ss of Facilit	-	uch Fu	inera	1 Home	Maryland
m	99 = 8		1 libers			127 So	uth 1	Main :					land 21901
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus one cause on each	ed the death. Do no line.	t enter the mo	de of dyin	g, such as	cardiac or	respiratory a	arrest,		Approximate Interval Between
	Pnysician	1	Immediate Cause (Final disease or condition	. V	ENTRIC	ULAR	F	ZIBK	RILLI	STION	V		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence of)	:							
		4	Sequentially list conditions,	b.	Myscari	InL	IN	FAR	ce Ti	6N			
18	nsit	ulu ulu	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01	13 & 001136Q461106 01)	•							
か、	be executed siclan and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	as a consequence of)	:							
8760,	× × 9			_ d.									
9	leath certifica attending ph I for use as th	Physician/Medical	IF FEMALE:										
Вох	ath ce ttendi or use	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	ne of pregnancy 2 Fetal death	3 □Ectopic p	regnancy				2	3d. Date of deli	•
o.	the all	slcl	1 Yes 2 No	4☐Pregnant 9☐Unknown	at time of death	5 Other (s	pecify)					Month	Day Year
Δ.	The law requires that the de ite has been signed by the a page 2 should be detached		Part II. Other significant conditions of	contributing to death	but not resulting in the	ne underlying	cause dive	an in Part I		23e. Did	tobacco us	se contribute to	the cause of death?
Records,	uires tha signed Id be de	d by	^	ARTER	•	, 3			•		Yes 2		bably 4 Munknown
COL	w require been signature	lete					,	,		24a. Was	20	24h Were aut	opsy findings available
Re	The lav ate has page 2:	Completed	Hypertens							auto	psy ormed?	prior to death?	ompletion of cause of
Vital		a	25. Was case referred to medical	STEPOL	Chila			26 Piace	of Death	1 Yes		1 🗆 Yes	2 No
<u>></u>		O B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpa	tient 2 ER/Outp	atient 3 D	OA Othe	0.5				☐Other (Spec	ify)
n of		Ju: T	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Ir (Month, L	njury 28b. Tin Day Year) Inju		28c. Injury Work			3d. Describe			
Ö	Attending ir death. ector; Alter by the fune	atle	2 Accident investigation	n		М		Yes 2 □i	No				
Division	il or Attend after death Director: / I in by the f	Certification;	3 Suicide 6 Could not be determined	28e. Place of I	njury - At home, farm etc. <i>(Specify)</i>	, street, factor	y, office		2		Street and wn, State)	Number or Rui	ral Route Number,
	pital ours a seral C		200 Cartifica		at at any least of all a		1 - 4 4b - 4	- d-6	<u> </u>				
	24 hc 24 hc Fun etely (edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	niner: On the basis and manner	st of my knowledge, o of examination and/o stated.	or investigation	n, in my op	ne, date and pinion, deat	id place, ar ith occurre	d at the time,	date and	and manner as place, and due	stated. to the cause(s)
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier			29	c. License	number			29d. Date	signed (Month	, Day, Year)
			College Vien	ger M	D		0005	79131	/	1	ARCH 9	3 2005	-
	h		30. Name and address of person who	completed cause of		pe, Print)						, , , , , , , , , , , , , , , , , , , ,	
	9		The MAS DUGGAN.	1 4 41 - 5	707 NOR-	Th Si	Ree	TR	31t	TUN M	10	1901	
	Sta		31. Date filed (Month, Day, Year)	N N	strar's Signature	carle							
	Registr	aı	MAR 2 8 200	JO Decide	as SS A	-							

208	30		Please I				Ensure All Copie		:
			For	State of M	aryland / Dep	artment of H	ealth and Mental F	łygiene 🛭 🗎 🖔	12234
			State Registrar		Ce	rtificate of l	Death	Reg. No.	
	0.		1. Decedent's Name (First, Middle, Last)				2. Date of		3. Time of Death
	Physici		Nellie Adams	McArt	hur		Month March	23 2005	1:37 P M
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	4c. County of Death	
1	LXdiiii	101	Leonardtown Road near I	Prince Fred	erick Road	Hughes	ville	Charles	
	Funeral		5. Social Security Number 6. Sec	7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. 8. Date of		place (State or Foreign intry)
	Director	1	238-50-8823]M 2[3 }F	69 Yrs.	Months Days			h Carolina
	D		Usual Residence of Decedent				1000	23,1935 11,010	n ourorina
	nylan how		10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits
	B-f.a	1010	MD St. Mary	7 s	Mechani	csville			1 ☐ Yes 2 🔀 No
	7 28	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What Cou	intry?
	h wit	a D	37640 Asher Road			20659		U. S. A.	
	deat	by Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi	spanic Origin? (Specify Yes or n, Mexican, Puerto Rican, etc.)	No- 14. Race - Amer	
စ္	after or Ita	品	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 🔀	No				, etc.
93	ral'.	1 by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 Yes 2 No	Specify:	Specify: Wh	ite
5-(be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "naturel", or Itams 23a or 28a-1 ahow avant, the Medical Exacting Final be I celified at	Completed	15. Decedent's Edu (Specify only highest grade	cation e co <i>mpleted)</i>	16a. Dece	dent's Usual Occupa	ation during most of working	16b. Kind of Business/I	ndustry
21	within ene. than "	du	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired)		
2	filed w Hygier othar th	S	10		Hom	emaker		At Home	
р	be fill	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Midd	dle, Maiden Sumame)	
Maryland 21215-0036	should be and Mental s markad o umatic ava	2	James Benjamin Ada	ams			Maybelle S. Va	aughn	
ar		1	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street a	and Number or Rural Route Num	nber, City or Town, State, Zi	p Code)
	C = N =	33	Kathy H. Wolfe / I)aughter	3950	l Thomas I	Drive Mechanics		
Ore	of jo		20a. Method of Disposition 15☐8urial 2 ☐ Cremation 3 ☐ P	lemoval from State	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other plac	March 29,	20c. Location - City or T	own, State
Ē	Pages nent of ant: If it ury or o		4 □ Donation 5 □ Other (Specify)		Resurrect	tion Cemet	tery 2005	Clinton, Ma	ryland
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service License	of Col	2:	2. Name and Addres	s of Facility Brinsfiel	ld-Echols Fun	1.Hme.,P.A.
_	90 F F 9	0	Lour 18st	TXX	M00641 30	0195 Three	e Notch Rd. Cha	arlotte Hall,	MD 20622
П			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused ne cause on each li	the death. Do not en	ter the mode of dying	g, such as cardiac or respiratory	y arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Head	and nort	Inture	00		Onset and Death
	/Medical		resulting in death)		a consequence of):	injuri			
	Examiner								
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):				
	outed id ansil	Examine	Cause (Disease or injury that initiated events						
0,	te be executed ysician and ie burial-transit		resulting in death) Last	Due to (or as	a consequence of):		-		
760,	te be ysicii ie bu	cal		1					
89	death certificate e attending phy: od for use as the	Physician/Medi							
Вох	n cer andir use	Ş	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome		75		23d. Date of deliv	ery
	90	Icla	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at		□Ectopic pregnancy □ Other <i>(specify)</i>		- Month	Day Year
P.0	that the de ed by the a detached	hys	9 □ U <i>n</i> known	9□ Unknown					
S, F	es tha igned be de	by P	Part II. Other significant conditions cor	tributing to death b	ut not resulting in the u	nderlying cause give	en in Part I. 23e. Die	d tobacco use contribute to	the cause of death?
rd	= sp						1	∐Yes 2ѼXNo 3∐Pro	bably 4 Unknown
8	faw requas been 2 shoul	ompleted					24a. W	as an 24b. Were auto	opsy findings available
Be	The ta ate ha page 2	mo					pe	rformed? death?	ompletion of cause of
Vital Record		Ö	25. Was case referred to medical				26. Place of Death (Check onli		2L No
5	cer	OB	examiner?	lospital:	ent 2 ER/Outpatier	t 30 DOA Othe			fuet geone
o	y Phys ar this aral di	Ė	27. Manner of Death	28a. Date of Inju	ry 28b. Time o			e how injury occurred	mat scene
Division	Attanding Indeath. actor: After by the funer.	tlo	1 ☐ Natural 5 ☐ Pending 2 🕱 Accident investigation	(Month, Da Morch 23	y Year) Injury 2005 (1.32		res 2000 funt	sect passary	eer w
/isi	after death. after death. I Diractor: A d in by the fu	fice	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj	ury - At home, farm, sti		28f. Location	(Street and Number or Run	al Route Number,
á	after after Directory	Certification;	4 Homicide determined	building, et	c. (Specify)		NB RF	5 NM 1 R	1231
	9 Hospital or Attand 24 hours after death 8 Funaral Diractor: /		29a. Certifier 1 ☐ Certifying Phys	sician: To the best	of my knowledge, deat	h occurred at the tim	e, date and place, and due to the	ne cause(s) and manner as s	stated.
	e Ho a Fu letely	edical	(Check only 2. Medical Examinations)	ner: On the basis o and manner st	f examination and/or in ated.	vestigation, in my op	pinion, death occurred at the tim	e, date and place, and due t	o the cause(s)
	To the Hosl within 24 ho To the Funs completely f	₩	29b. Signature and title of certifier			29c. License	number	29d. Date signed (Month,	Day, Year)
	7 - 0		Janla R.	Mos I	D- MAN	00	CME	March 24,	2005
r		13	30. Name and address of person who co	mpleted cause of o	leath (Item 23a) (Type	Print)		ratell 24,	2007
X	Ali		Jasha Z Green b	4.0	D		enn Street Bal	timore, Maryl	and 21201
4	Sta	te	31. Date filed (Month, Day, Year) MAR 2 8 20	32 Rajstr	ar's Signature	_		y mary	21201
	Registr		MAR 2 8 20	105	we to p	parke			

			1 - For State Registrar	State of Maryl		artment of Heartificate of De	aith and Mental I eath	-lygiene	15 12235
	Physic /Medi Examir	cal	1 Decedent's Name (First, Middle, Richard A. Facility Name (If not institution, Richard River)	give street and number) 25 Hospital (Micenter	Feely 4b. City, Townfor Lo Cheste	rtown	L Day L 26 20 4c. County	
	Funeral Director		5. Social Security Number 143–26–5925 Usual Residence of Decedent	3. Sex 7. Age (In y	yrs. last birthday) 71 Yrs.		Hours Min. 8. Date of (Month Decem	ber3,1933	9. Birthplace (State or Foreign NJ
	Maryland B-f show	ctor	10a. State 10b. County		City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	3a or 28	ai Dire	10e. Street and Number 509 Fey Road			10f. Zip Code 2162	20	10g. Citizen of W	/hat Country?
980	s 1 and 2 should be filed within 72 hours after death with tha Maryland f Health and Manlat Hygene. Item 27 is marked other than "natural", or iteme 23a or 28a-1 show other traumatic event. Ite Medical Execution art mart be profiled at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? d IXXYes 2 □ No If Yes, Give Year or Dates:			anic Origin? (Specify Yes o Mexican, Puerto Rican, etc. Specify:		e-American Indian, k, White, etc. White
21215-0036	within 72 ho lene. r than "natur the Medical	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done during DO NOT use retired) cinarian	on ing most of working	16b. Kind of Bu	siness/Industry
Maryland 2	should ba filed ind Mantal Hygie markad other umatic event.	To Be C	17. Father's Name (First, Middle, La Richard Harding	ast)		18	Mary Nancy V		a)
	and 2 sho ealth and h n 27 is me		19a. Informant's Name/Relationship Lynne Klunder-M				Number or Rural Route Nu Chestertown,		State, Zip Code)
Baltimore,	Pages 1 and 3 nent of Health int: if item 27 iry or other tr		20a. Method of Disposition 1	Bemoval from State		matory or other place)	n March28,20		City or Town, State
Balti	permit, Pages, Department of Himportant: If ite any injury or of once.		21. Signature of Funeral Service Lie						ral Home, P.A. 1620
	Fhysician /Medical Examiner	er	23a Fart1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	aSeps	sequence of):	er the mode of dying, s	such as cardiac or respirato	ry arrest,	Approximate Interval Between Onset and Death
8760,	that the death certificate be exacuted ed by the attending physician and detached for use as the burial-transit	dicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):				-
P.O. Box 6	at the death certific by the attending pl tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)		23d. Date Mon	o of delivery th Day Year
	law requires that as baen signed t 2 should be det	by	Part II. Other significant condition:	s contributing to death but not	resulting in the u	nderlying cause given in			bute to the cause of death? 3 Probably 4 Unknown
Vital Records,	The ate h page	Completed	3) Periplies	al sitema	& Dis	eare	24a. V	utopsy pr erformed? de	fere autopsy findings available itor to completion of cause of sath?
of	iding Physician: Th th. After this certificate funeral director, pag	tion; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo 27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigal	28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time of Injury	other: 28c, Injury at Work?	5. Place of Death (Check or 4 Nursing Home 5 R 28d. Descri		
=	To the Mospital or Attending Phwithin 24 hours after death. To tha Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not determine	t be 280 Bloom of Injury A	at home, farm, str ecify)		28f. Location	n (Street and Numbe Town, State)	r or Rural Route Number,
	he Hoepital in 24 hours a' ha Funeral D pletely fillad i	edical	29a. Certifier 1 D Certifying (Check only one)	Physician: To the best of my laminer: On the basis of exam and manner stated.	knowledge, deatl sination and/or in	n occurred at the time, ovestigation, in my opinion	date and place, and due to on, death occurred at the tire	the cause(s) and man	ner as stated. nd due to the cause(s)
)	To the within 24 To the Complete	M	29b. Signature and title of certifier	cm, M.D.	•	29c. License nu	3/3	3/26/	(Month, Day, Year)
				o completed cause of death (I	Item 23a) (Type, Wask	Print)	Ave., Ches	Cestown,	mp 21620
1.7	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 2 9	32. Registrar's Sig	gnature	60		,	

				For Stete Registrar	State of	of Marylar	•	rtment tificate			Mental Hy	gien Reg. N	000	12236
				Decedent's Name (First, Midd	le, Last)				0. 00		2. Date of De	ath		3. Time of Death
_		Physici /Medi		MILTON M. MULI	TZ						MARCH	21.		7:10 A M
		Examir		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, To	wn, or Lo	cation of Death			c. County of Death	1, 1, 4, 4, 5, 55
				SUBURBAN HOSPI					THESI				MONTG	OMERY
		Funeral Director		5. Social Security Number 578-32-3615	6.Sex ¾ □M 2□F	7. Age (In yrs.				Under 24 Hrs. lours Min.	8. Date of Bir (Month, Da MARCH	th 17. Year 27 ,	9. Birthr Cour 1918 WAS	place (State or Foreign ntry) HINGTON, DO
		and land		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
		Marylan -f show fled st	ţō	D.C.	NONE		-	HINGTO	N					1 XYes 2 No
		h the r 28a r ceti	Director	10e. Street and Number				10f. Zip Ce	ode			10g. Ci	itizen of What Cour	ntry?
		23a c		2700 VIRGINIA A	VENUE, NW	APT 12	01		20037	,			U.S.A.	
		er dea tems	Funerai	11. Marital Status	Armed Fo		1	Vas Deceder Yes, specify	nt of Hispa Cuban, N	nic Origin? (Sp lexican, Puerto	pecify Yes or No Rican, etc.)	-	14. Race - Americ Black, White,	
	36	be filed within 72 hours after death with the Maryland ital Hygiene. bd other than "natural", or Items 23a or 28a-f show evant, the My Jical Examiner must be notified at	by F	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 XYes If Yes, Gi Year or D	2 No WW	TT	☐Yes 2☐		pecify:		ŀ		ITE
	21215-0036	2 hou	ted t	15. Deceder	nt's Education		16a. Deced	ent's Usual (Decupation	1		16b. k	Kind of Business/Inc	dustry
	215	thin 7:	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College ((Give	kind of work of NOT use	done durir retired)	ig most of work	king	15511		accuy
		ygien ygien t, th	Con		4	,	OWNER-	-EXEC-	PRESI	DENT		MIS	C. IRON	WORKS
	Maryland	nd 2 should be filed within alth and Mental Hygiene. 27 Is marked othar than " 7 traumatic evant, the Me.	Be	17. Father's Name (First, Middle,	Last)				18.		ne <i>(First, Middle,</i> HA GLAZ]		n Sumame)	
	ž	hould d Mer marke	2	HARRY MULITZ 19a. Informant's Name/Relations	ship (Tuno Brint)		10h Mailin	- 144 (6					or Town, State, Zip	
	Ma	nd 2 s Ith an 27 fs		WENDY A. SPIVAK							LTIMORE			21210
	ē,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra once.		20a. Method of Disposition		20b. P	Place of Dispos	sition (Name	of		Date	20c. L	ocation - City or To	own, State
	E	Page nent o int: If		1 😾 Burial 2 □ Cremation `4 □ Donation 5 □ Other (5	3x∑Removal from Specify)	State WA	SHINGT GREGATI	ON ME	REW MI. PK	3/24	/2005	WAS	HINGTON,	D. C.
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	_	20E 29		Musey) 		T	. / U KU	CKATT	TE LIK	E, ROCK	$\Lambda T \Gamma \Gamma$	E, MARYL	AND 20852
				23a. Part1 Enter the disease, o shock, or heart failure. List	complications that only one cause on e	caused the death each line.	h. Do not ente	r the mode o	if dying, su	ich as cardiac	or respiratory a	rest,		Approximate Interval Between
		Physician		Immediate Cause (Finat disease or condition resulting in death)	a. ATHE	ROSCLERO	OTIC HE	EART D	ISEAS	E				Onset and Death
X		/Medical Examiner		rosaning in death)	Due to	(or as a consequ	uence of):							
7:10AM			er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. ————————————————————————————————————	(or as a consequ	uence of):					_		
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	ó	e exection and an arrial-tr	Exa	resulting in death) Last	Due to	(or as a consequ	uence of):							
S	68760,	eath certificate be executed attending physician and for use as the burial-transit	edicai		d									
_	9 xo	ding p		IF FEMALE:	22a If year out							Į.		
7	Bo	The law requires that the death certif Ite has been signed by the attending page 2 should be detached for use a:	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	tcome of pregna pirth 2 ☐ Fetal nant at time of de	Ideath 3 🗌	Ectopic pregr Other (specia					23d. Date of delive Month	ory Day Year
3	o.	tt the d by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno		5a(ii 5	Other (Specia	·y)					
	σ,	wrequires that the d been signed by the should be detached	by Pl	Part II. Other significant conditi	ons contributing to de	eath but not rest	ulting in the un	derlying caus	e given in	Part I.	23e. Did to	bacco	use contribute to th	ne cause of death?
1	rds	equire en sig	ed k	DEMENTIA							101	'es 2	□ No 3 □ Prob	ably 4 Hunknown
5	Vital Record	e law requ has been je 2 shoul	Completed								24a. Was		24b. Were autop	psy findings available
Milton	= H		Con								perfo	med? 2 srNo	death?	npletion of cause of 2 No
-	Vita	cian; ertific sctor,	Be	25. Was case referred to medica examiner?							h (Check only o			
\leq	of	hys his	L.	1 ☐ Yes 2 🛣 No 27. Manner of Death			ER/Outpatient 28b. Time of		Other:				6 Other (Specify	1)
7	on,	Attanding Ir death. sctor: After	tion	1 Natural 5 Pendir 2 Accident investi		of Injury th, Day Year)	Injury	28C.	Injury at Work?		28d. Describe h	iow injui	ry occurred	
-	Division	Attandi r death. actor: A by the fu	ifica	3 Suicide 6 Could	not be 28e. Place	of Injury - At ho	me, farm, stre				28f. Location (S	treet an	nd Number or Rura	l Route Number,
	Ö	s afte	Certification;	4 Homicide determ	buildi	ng, etc." (Specify	")				City or Tou	m, State	9)	
Mulitz		To the Hospital or Attandi within 24 hours after death. 7 to the Funaral Diractor: A completely filled in by the fu	Medical (29a. Certifier 1 X Certifyir (Check only one) 1 Medicel	ig Physicien: To the Exeminer: On the ba and mann	best of my know asis of examinat ner stated.	wledge, death ion and/or inv	occurred at to estigation, in	he time, d my opinio	ate and place, n, death occurr	and due to the ored at the time,	ause(s)	and manner as sta d place, and due to	ated. the cause(s)
		To the within To the comp	Me	29b. Signature and title of certifie	1			29c. Li	cense nu	nber		29d. Da	te signed (Month, L	Day, Year)
		6	1	mel	-			$oxed{\mathcal{D}}$	52	767		0	3/23/0	05
				30. Name and address of person DR. HARMINDER S					E #30	3, ROCK	VILLE,	MAR	YLAND 20	0852
		Sta Registr	5.	31. Date filed (Month, Day, Year) MAR 25	2005 R	egistrar's Signal	lure des	w						

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	·		Decedent's Name (First, Middle, Last))			tinoato	0, 00	74177	2.	Date of Dea	Reg. No.	- EL U ()	U	3. Time of Death	-1
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	/Medi Examir		4a. Facility Name (If not institution, give				4b. City, Tov	wn, or Lo	cation of		viav ev		County of [0	
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	and .		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wm or Lo	cation							146	4.1	
	Maryland -f show fied at	5					Cation							10	d. Inside City Limit 1X Yes 2 □ N	
	nthe Maryland r 28a-f show	Director	MARYLAND MONTGOMER' 10e. Street and Number	Y	ROCKV	LLLE	10f. Zip Co					40 014				
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Maryland	12 st hand 7 is n treun		19a. Informant's Name/Relationship (Ty												^{Code)} 20906	
e,	1 and Healt em 2	1 8	ENRIQUETTE HORER/DA 20a. Method of Disposition	AUGHTER	20b. Place	of Dispo	LEIS	URE	WORL	D BLV	D. #9		SILVE cation - City		PRING, MI	
lo	ages nt of E. F. if		1 Burial 2 Cremation 3 X F		ceme	tery, cren	natory or other	r place)			-					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene Important: If item 27 is marked other then "naturel; or Items 23a or entry injury or other treumatic event, I'm Medical Examinar must be ance.	1	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 		MT. H	-	Name and A		Eacility	/25/2	005 F	LUSH	ING,	LONG	G ISLAND,	N
Ba	Dep Imp eny	li li	Donald C. X	Starm.	· · · · · · · ·	DA 111	NZANSK 70 ROC	Y-GO KVII	LDBE	RG ME	MORIA	L CH	IAPELS	, I	NC.	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that cause	d the beath. Do	o not ente	er the mode of	dying, sı	uch as ca	ardiac or re	spiratory an	rest,	لللتا و ا		Approximate	
	Physician		Immediate Cause (Final	1.4											nterval Between Onset and Death	
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	Examiner		Sequentially list conditions,	2												
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68760,		dlcal		d												
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ğ	death a atte	ciar	in the past 12 months?		2 Fetal dea at time of death		Ectopic pregnation of their (specifical control of their (specifical control of their contr					^	Month		yay Year	
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of\	Physicien: this certificaral director, i	၉	1 □ Yes 2 □ No		ent 2 ER/C				Nursi	ing Home	5 🗆 Reside	ence 6	Other (S	pecity)		
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	spitel ours nerel filled		29a. Certifier 1 ☐ Certifying Phys	sician: To the best	of my knowledg	ne death	Occurred at th	e time d	ate and r	place and	due to the c	21150/5/	and manna	ac etc	ad	
	To the Hospitel or within 24 hours afte Fo the Funerel Dir completely filled in	edical	(Check only 2 Medical Exemination)	ner: On the basis of and manner s	of examination a	and/or inv	estigation, in n	ny opinio	n, death	occurred a	t the time, d	ate and	place, and	due to t	ne cause(s)	
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	2		Cansal	Mune	7000		0:	44	907			Mar	-cL	22	, 2005	
			30. Name and address of person who co	mpleted cause of	death (Item 23a) (Type, I	Print)	LINS	ivelo		1200	net	no			
			4105 Ma	npise	Rom	d	pod	Cul	h		410	2	085	- 2	•	
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	D 1		1. Decedent's Name (First, Middle, L.	ast)							2. Date of De	ath			3. Time o	of Death	_
	Physici /Medi		Gemma Dal Molin	ı							Month March	23.	^{ay} 2005	Year	8:20	a M	A
	Examir		4a. Facility Name (If not institution, gi	ve street and numbe	r)		4b. City, T	own, or	Location o	f Death		40	c. County	of Death			
				pital					Sprin					Mont	gomer	У	
	Funeral		,	Sex 7.7 1 □ M 2 1 F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birth	place (State ntry)	or Foreig	n
	Director		Usual Residence of Decedent		93	115.					Nov. 1	5,1	911	It	aly		
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation								10d. Inside (City Limits	
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	r 28e	Director	10e. Street and Number	J. I. C. L. Y		<u></u>	10f. Zip 0		J			10g. C	itizen of W	hat Cou	ntry?		_
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	deat	Funeral	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.S	S. 13.	Vas Decede	nt of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.))-	14. Race	- Ameri	can Indian,		
õ	d within 72 hours after death with the Maryland jone. ir then "natural", or Items 23e or 28e-f show the Medical Exercities the recitified at	E.	1 Never Married 2 Married	1 Yes 25			ives, specii I⊡ Yes 2		Specify:	, Puerto	Hican, etc.)	1		, White,			
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	permit. Pages 1 and 2 should be filed w Department of Health and Mental hygie Importent: If item 27 is marked other tany injury or other treumatic event, III DDCE.		Elio Dal Molin	/ Son		95	16 Gw	vnda	ale D	rive	Silve	ar S	nein	. 17	n 2001	1.65	
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5	after after Dire	ert	4 Homicide determined	building, e	tc. (Specify)	, , , , , , , , , , , ,	or, radiory, c	511100			City or Ton	n, State)	G/ / ID/ Q	710010 74011	1001,	
	spite hours inere		29a. Certifier T Certifying Ph	nysicien: To the bes	t of my know	vledge, death	occurred at	the time	e, date and	place, a	nd due to the o	ause(s)	and man	ner as st	ated.		-
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	Medical	(Check only 2 Medical Exar	niner: On the basis and manner s	oi examinado	on and/or inv	estigation, in	my opi	nion, death	occurre	d at the time, o	date and	piace, an	d due to	the cause(s	i)	
	To t To t	Σ	29b. Signature and title of certifier	Λ	1	_	29c. L		number		-				Day, Year)		
	6		lilan K	. log	alk	my		ט	52261			Ма	rch .	24,	2005		
	4		30. Name and address of person who Alan R. Segal,					. ~	4 T	~							
	C.		31. Date filed (Month, Day, Year)		rar's Signatu		TEGTE	;, S	TTAGL	spr	ing, M	υ 20	1906				
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 0 5

1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 10:15/ 2005 March Charles Leroy Metz, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington County 980 Northern Ave Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1XM 2□ F Yrs Director 76 213-24-9113 May 1 1928 Maryland fited within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show i of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 shov or other traumatic event, I're Medical Examinar must be notified at Director 1 ☐ Yes 2 X No Maryland
10e. Street and Number Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 980 Northern Avenue 21742 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Livestock Dealer Public Auction Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked of ٥ William E. Metz Gladys Hammond Metz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11823 Bradford Drive Hagerstown Maryland 21742 Charles Leroy Metz, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Mar 28 2005 Smithsburg Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ATHERO SULERUSIS unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 physician the IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed? ,24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mayor of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier ause of death (Item 23a) (Type, Print) JH-5 Medical Campus Ko MD 11110 32. A gistrar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** Month Jane Estella McKinsey March 27, 11:35 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood Hilltop Assistant Living Williamsport Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex Birthplace (State or Foreign Country) Days Hours 1 ☐ M 21K] F Yrs. 93 Director 219-66-2186 Dec.5,1911 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other treumatic event. The Medical Examiner must be nutified at Md. Washington Williamsport Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 16505 Virginia Ave. 21795 or Items 23a U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White à Specify: 3√ Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) then filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked ofth any lighty or other treumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Charles Warrenfeltz Cora Stouffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris June Zicari (Daughter) 99 Sagamore Dr. Rochester, New York 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 31. 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Cemetery Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Congestive Heart disease or condition resulting in death) 1 years /Medical Due to or as a consequence of): **Examiner** Atherosclerotic Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mooths? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Mellitus 1 Yes 2 TNo 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Wither (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ASSISTED 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number Cynthia Kutther-Sands mo D47451 March 28 2005 Nomewood at 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Williamsport, 16505 Virginia Avenue Kuther-Sands no 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mantal Hygiene

			1 - State Registrar	State of M	aryland / Dep Ce	entificate of		Mental H	/giene Reg. No.	200	5 122
V	Physi	de cian	1. Decedent's Name (First, Middle,				LT.	2. Date of D	eath Day	Year	3. Timo of Death
1	/Med Exam	lical	nope benson M	achedon	1	4h City Town o	r Location of Death		03, 2	005	8:15 A M
4	LAGIN		7804 Leesburg D			Bethesda			3	ound of Death Egomery	v
	Funera Directo		069-60-8287	6. Sex 1 □ M 2 □XF 7 Ag	e (in yrs. last birinday) 44 Yrs.	Monins Days	d Under 24 Hrs. Hours Min	a. Oale of Bi (Month, D June 1	rth ev. Year)	9. Binho	place (State or Foreign
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	ain the Maryland a or 28a-f show	Director	10e. Street and Number			10f. Zip Code			10g. Citizan	of What Coun	itry?
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e,	l ard Health Am 23		Matei Machedon/Y 20s. Method of Disposition	usband	7804 20b. Place of Dispo	Leesburg	Drive Be	thesda,			
I OIL	Pages I van oli II int: Hite iry or off		3 □ Buriel 2 🖺 Gremation 3 4 □ Denation 5 □ Other (5pe	☐Removal from State	W. Arunde	natory or other place	, mer ci			n - City or Tow	
Balti	Fermit. Page Department of Importent: H any injury or		21 Signature of Funeral Service Lice B2112 41 4.4		G0	Name and Andress	of Feculty Cremation	Servi	ח ש פס	n, Mary	yland 784 , MD 21029
	E		23a. Pan1. Enter the disease, or co	mplications that caused by one cause on aach in	the daste. On our oats	or the mode of dying,	, such as cardiac of	rospiratory an	OISIK		Approximate
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Theresa Neicen 145-28-8614

			1 - For Amend Item 23a	State of Marylan -b&25 per me	€842 p2 <i>Cer</i>	rtment of Hatificate of L	ealth and M Death	lental Hyg	jien <u>e</u> () ()	5	12242
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th		3. Time of Death
	Physici /Medi		Theresa A. Neic	en				Month MARCH	24 2	Vear	0230 M
	Examir		4a. Fecility Name (If not institution, give st	reet and number)	2	4b. City, Town, or	Location of Death		4c. County of	_	
			Geninsula Region	of Medical	CONTE	50,	Isbury			mico	
	Funeral Director		5. Social Security Number 6. Sex 145-28-8614	7. Age (In yrs. I	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 9/10/19) 37	Counti	ce (State or Foreign Y) Jersey
	land ow		10a. State 10b. County	10c. City	y, Town or Lo	ation				10	d. Inside City Limits
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	or 28e	Director	10e. Street and Number			10f. Zip Code	····	1	0g. Citizen of W	hat Counti	y?
	23e c	alD	26412 Creek Wood C	ircle		19966			US		
	r dea	Funeral	11. Marital Status	2. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp.	ecify Yes or No-		- America	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. dother then "neturel", or terms 23e or 28e-1 show event, I'm Mudfeel Evert act must be routiled at	by	1 ☐ Never Married 2 反 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		☐ Yes 2½ No	Specify:	,		whit	
2-0	72 ho	Completed	15. Decedent's Educa	ation	16a. Deced	ent's Usual Occupa	tion	-	16b. Kind of Bus	siness/Indu	ıstry
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Maryland	2 should be filed within and Mental Hygiene. is marked other then eumetic event, the Ma	Be	17. Father's Name (First, Middle, Last) Leonard Lawless				18. Mother's Name	e <i>(First, Middle, I</i> ne Keber		9)	
ž	should ind Men ind marke umetic	To	19a. Informant's Name/Relationship (Typ	o Print)	10h Mailin	Address (Street a				. 7: 0	
	s 1 and 2 should f Health and Men item 27 is marke other treumetic		Edward L. Neicen/			Creekwoo					
ore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	20b. P	lace of Dispos	ition (Name of atory or other place)	Date	20c. Location - C	City or Tow	n, State
Baltimore,	Pa anti-		`4 ☐ Donation 5 ☑ Other (Specify)	Cape	ematory	pen	3/25/	05	Frankfor	rd, D	elaware
Bal	permit. Departr Importe any inji	1	21. Signature of Fundal Service London	how	Me1	Name and Address son Funer g Neck Ro	al Servi	ces, Lt	d.		
			23a. Part Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death cause on each line.	n. Do not ente	r the mode of dying	, such as cardiac o	or respiratory arre	est,	í	Approximate nterval Between
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	/Medical Examiner		Tooling in doding	Due to (or as a consequ	uence of):)		-		0
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oʻ	cate be executed bhysician and the burial-transil	Exa	resulting in death) Last	Due to (or as a consequ	ience of):	, , , , , , , , , , , , , , , , , , , ,	\wedge	1//	0		
8760,	cate be physici the bu	dlcal	d.				11		TAL EXAMINER		
9		0	IF FEMALE:					WEDB ME	WICHT	1	
Вох	eath certifi attending I for use as	ian/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnar 1☐Live birth 2☐Fetal	death 3 🗌	Ectopic pregnancy	tox	APPROVED	23d. Date Mont	of delivery	ay Year
o.	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5⊔	Other (specify)	CERTIFIL		23d. Date Mont	-	-,
<u>α</u>	s that ned b e deta	by Pt	Part II. Other significant conditions conti	ibuting to death but not resu	Ilting in the un-	derlying cause giver	-		acco use contrib		cause of death?
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/ita	Physicien: Th this certificate al director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death				
7	hys his	2	A res Z no		ER/Outpatient		4 Nursing Hot				
n (ding Ph h. After th funeral	ion	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?		28d. Describe ho	w injury occurred	d	
Division	ten leat tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hor	me farm etro		es 2 No	28f Location (Str	eet and Number	or Pural I	Toute Alumbar
<u> </u>	el or A	Certification:	4 Homicide determined	building, etc. (Specify,)	et, ractory, office		City or Town	, State)	OI HUIGI F	lonta ianimper'
	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the funere	ledical (29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my knov r: On the basis of examinati and manner stated.	vledge, death ion and/or inve	occurred at the time estigation, in my opin	, date and place, a nion, death occurre	and due to the ca	use(s) and manr ite and place, an	ner as stated	ed. ne cause(s)
	To the within 2. To the complete	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed ('Month, Da	y, Year)
			· mo	MO		1)560	793		-3/24	105	
			30. Name and address of person who com	pleted cause of death (Item	23a) (Type, P	rint)	-		-		-
			560 Riverside	P Suite	200	Leis.	2,00	0 3	e /		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 8 20	pleted cause of death (Item	J. J.	parle	9				

		l.	For State Registrar	State of Maryla	nd / Depa		Health		ygiene 0 0 5	5 12243
			Registrar 1. Decedent's Name (First, Middle	la Last)	Ce	Tillicate Of	Dealli	2. Date of D	Reg. No.	3. Time of Death
П	Physici	an						Month	Day Ye	9ar M
	/Medic		Barbara Neust			4b. City, Town,	or Location	March	22 2 4c. County of I	005 7:30 A
П	Examin	er						or boatt		
	Funeral		121 Academy 5. Social Security Number		s. last birthday)	Annapo	r If Under	24 Hrs. 8. Date of B	irth Anne A	. Birthplace (State or Foreign Country)
	Director		577-40-5676	1□ M 20 X F 74	Yrs.	Months Days	Hours			Kentucky
	p.		Usual Residence of Decedent					Odile	20, 1331	
	arylar	_	10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	8e-f	Director		Arundel A	nnapoli	s				
	ar death with the Marylan tems 23e or 28e-f ehow et mast be mailfed at	Dir	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	s 23	ra	121 Academy S	treet	11.6 12	214		igin? (Specify Yes or N	United S	tates American Indian,
	ltems	Funeral	11. Marital Status 1 Never Married 2 Mar	12. Was Decedent Ever in Armed Forces?	0.5.	If Yes, specify Cu	ban, Mexica	n, Puerto Rican, etc.)	Black, V	White, etc.
39	al', or	by F	3 ₩idowed 4 Divorced	If Yes, Give A		1 ☐ Yes 2 N	Specify.		Specify:	white
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f ehow re Madical Ever in art reast be tredified at	ted	15. Deceder	nt's Education	16a. Dece	dent's Usual Occi	pation	I-I-1	16b. Kind of Busin	
212	hin 7 9. "n Medi	ple	(Specify only night Elementary/Secondary (0-12)	college (1-4or 5+)	life.	kind of work don DO NOT use retir	ed) ed)	st or working		
2	filed wit Hygiene other the	Completed	, , ,	4	Pu	blic Rei	lation	S	self e	mployed
2	d oth	Be (17. Father's Name (First, Middle,	Last)			18. Moth	er's Name (First, Middi	e, Maiden Sumame)	
Х	2 should be and Mental is marked o	၉	Howard Donald					ildred Elea		
Maryland	2 sh and is m		19a. Informant's Name/Relations	ship (Type, Print)	19b. Maili	ng Address (Stree	at and Numb	er or Rural Route Num	ber, City or Town, Sta	ite, Zîp Code)
	permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel; or I amy injury or other treumetic event, the Nedical Exertinantice.	1	Pamela Polgree	en/ daughter	Place of Dispo	Sumper I	kd. An	napolis, M	21401	y or Town State
0	Pages nent of H ent: If ite ury or of		1 ☐ Burial 2 ☐ Cremation	3 □Removal from State	cemetery, cre	matory or other pi	ace)	20.0	E. Cocation On	y or rown, orace
Ħ	t. Pa rtmer rtent riury		`4 □Donation 5 □Other (\$	Specify) B	altimor	e Cremat	ory	3-24-05		
Baltimore,	Depa Depa Impo In in		21. Signature of Funaral Service	t Penales	1			John M.	Taylor Fu	neral Home, In
			23a Part1 Enter the disease of	r complications that caused the dea	ath. Do not en	47 Duke	of GL	oucester Si	. Annapol	is, MD 21401
			shock, or heart failure. Lis Immediate Cause (Final	t only one cause on each line.	1	VNG		,	,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	- CANCER		0100				J mus
	Examiner			Due to (or as a conse	equence oi).					
	DAY S	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S .						
ó	sician and burial-transit		resulting in death) Last	Due to (or as a conse	equence of):					
3760,	w ~ w	Ical		d						
39	leath certificat attending phy I for use as th	Med	IF FEMALE:			-				
Вох	ath ce ttend or use	Physiclan/Med	23b. Was decedent pregnant	23c. If yes, outcome of preg 1 Live birth 2 Fe	tal death 3	Ectopic pregnan	су		23d. Date o Month	f delivery Day Year
O.	the a	/sic	in the past 12 months? 1 □ Yes 2/2 No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)			4	,
Δ.	The law requires that the de ate has been signed by the a page 2 should be detached f	Ph		ions contributing to death but not re	esulting in the u	nderlying cause o	iven in Part	23e. Did	tobacco use contribu	ite to the cause of death?
ds,	uires tha signed d be dei	d by		3.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1	, , , , , , , , , , , , , , , , , , ,	,	,		Yes 2 □ No 3[☐ Probably 4 ☐ Unknown
Ö	v requir been si should	Completed						24a. Wa	e an 24h War	re autopsy findings available
Record	has has ge 2	m						aut	opsy prio formed? dea:	r to completion of cause of th?
	icien: The l certificate ha rector, page		05 18/an anna referend to madin				on Di-	1 Ves		Yes 2□ No
Ĭ		o Be	25. Was case referred to medical examiner? 1 \(\sum \) Yes 22\(\sum \) No	Hospital:	☐ ER/Outpatie	nt 3 DOA		e of Death <i>(Check only</i> ursing Home		(Specific)
Division of Vital	Physical dispersion of the standing of the sta	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)			ury at		how injury occurred	Specily)
0	th. : After a funera	tlor	12 Natural 5 ☐ Pendi 2 ☐ Accident invest	ing (Month, Day Year)	Injury		ork? ⊒Yes 2.⊑	No		
N N	l or Attending after death. Director: After I in by the fune	ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office	Э		(Street and Number o	or Rural Route Number,
Ö	in Sign	Certification:	4 Horricide	building, etc. (Spec	uny)			Only of 7	own, State)	
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in			ng Physician: To the best of my ki						
	the H in 24 the F	Medical	one)	and manner stated.				at the time		
	To With	2	29b. Signature and title of certific		/	29c. Lice	nse number	15	29d. Date signed (A	Onth, Day, Year)
			/ Jack	11 Worth	nh	100	811	0	11/1/01/01	00,000
			30. Name and address of person	who completed cause of death (Ite	VN	Print) DO	BEST	OPTE NO	ANNO	122,2005 Julis mo 21401
	Sta Registi		31. Date filed (Month, Day, Year		nature	Souls 1				
			1							

			For State Registrar	State of Maryla		artment of F		d Mental Hy	giene	5	12244
			1. Decedent's Name (First, Middle, Last)					2. Date of De	aath Day	Year	3. Time of Death
	Physici /Medic		George Moffat Nam	ning'ona					16, 200		6:40 P M
7	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of D	eath	4c. County	of Oeath	
			Holy Cross Hospit				lver S				omery
	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 I	Ain. (Month, Da	th ay, Year)	9. Birthp Cour	place (State or Foreign ntry)
	Director		579-82-5970 Usual Residence of Decedent		55 Yrs.			Sept. 2	6, 1949	Ma	lawi
	land ow		10a. State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits
	Many Many	tor	Maryland Monto	omery	Olney						1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number		02.10)	10f. Zip Code			10g. Citizen of \	Vhat Cour	ntry?
	th with		17300 Evangelin	ie Lane		208	32		U	SA	
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	ispanic Origin	? (Specify Yes or No uerto Rican, etc.))- 14. Rad	e - Americk, White,	an Indian,
98	or It.		1 ☐ Never Married 2 ☒ Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 🗹 No	Specify:	dorio / llodri, oto./	1	Blac	
21215-0036	4 within 72 hours after death with the Maryland Jione. I than "natural", or Itams 23a or 28a-f show It e Macilcal Examination and be notified at	d by	3 Widowed 4 Divorced	Year or Dates:							
7	n 72 nat	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	dent's Usual Occup kind of work done o DO NDT use retired	ation during most of	working	16b. Kind of B	ısiness/In	dustry
12	within ene. than	mc	Elementary/Secondary (0-12)	College (1-4or 5+) 4		iter Prog			Comput	0 m C	on au 1 t i na
9	The H		17. Father's Name (First, Middle, Last)	-	Compe	icci ilog	· · · · · · · · · · · · · · · · · · ·	Name (First, Middle			onsulting
Maryland	o c a o	To Be	Edward Wilson Mof	fat Naming'	ona		E	lina Matol	la		
ary			19a. Informant's Name/Relationship (Type	oe, Print) -Wife	19b. Mailir	ng Address (Street	and Number o	r Rural Route Numb	er, City or Town,	State, Zip	Code)
	is 1 and 2 of Health a itam 27 is other tra	,	Kathryn M. Brown-N	Taming'ona	17300) Evangel	ine Lar	ne, Olney,	Maryla	nd 20	0832
ore	of He of He fitan		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ R		 Place of Dispo cemetery, crer 	sition (Name of natory or other place	(e) z	April 9,	20c. Location -	City or To	wn, State
Ē	nit. Pages artment of ortant: If i injuryer		'4 □Donation 5 □Other (Specify)	I I	Metropol	itan Crema	atory	2005	Alexand	ria,	Virginia
Baltimore,	permit. Pages 1 Department of He Important: If iten any injuryer oth		21. Signature of Funeral Service License	Deler Steller	Ff	Name and Address OO Univer	sity B1	ıs Funeral .vd, W, Si	Home I lver Sp	nc ring,	Md 20901
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the de le cause on each line.	eath. Do not ent	er the mode of dyin	g, such as car	diac or respiratory a	rrest,		Approximate Interval Between
	Pnysician :	ev i	Immediate Cause (Final disease or condition	IDIOPAT		PULMO					Onset and Death MONTHS
	/Medical Examiner		resulting in death)	Due to (or as a cons							
	Examine	_	Sequentially list conditions, b								
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury	Due to (or as a cons	sequence of):						
	be executed ician and burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a cons	equence of):					-	
8760,	sate be executed physician and the burial-transit	E E									
687	death certificate e attending phys ed for use as the	edlcal									
Вох	eath certific attending p for use as f	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pred 1□Live birth 2□F		Ectopic pregnancy			23d. Dat	e of delive	ry
4	death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (specify)			Мо	nth	Day Year
P.0	that the de led by the a detached i	hys	9 🗆 Unknown								
Vital Records,	sign d be	þ	Part II. Other significant conditions con	tributing to death but not r	resulting in the ur	nderlying cause give	en in Part I.		obacco use cont Yes 2□No	ibute to th 3 ☐ Prob	ably 4 Munknown
000	aw Is b	ompleted						24a. Was		Vere auto	osy findings available inpletion of cause of
Ä	9 4 6							10 Yes	rmed?	leath?	2 No
'ita	lcian: Th certificate ector, pag	BeC	25. Was case referred to medical examiner?				26. Place of	Death (Check only o			
of V	ys dir	2	1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 2	☐ ER/Outpatien		4 U Nursin	g Home 5 🗆 Resi	dence 6 Oth	er (Specify)
n o		on;	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe	how injury occurr	ed	
Sio	ten feat tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be	Pl (1)			Yes 2 □ No	20() (
Division	or Attendation of Director:	Certification;	4 ☐ Homicide determined	28e. Place of Injury - Al building, etc. (Spe		eet, factory, office		City or To	Street and Numb vn, State)	er or Rura	I Houte Number,
1	a Hospital 24 hours a a Funaral l		29a. Certifier	ician: To the best of my k	nowledge death	occurred at the tin	ne, date and ni	ace, and due to the	cause(s) and mo	nner as ct	ated
	To tha Hospital or At within 24 hours after or To tha Funaral Direct completely filled in by	edical	(Check only 2 Medical Examination)	er: On the basis of examinand manner stated.	ination and/or inv	estigation, in my of	pinion, death o	ccurred at the time,	date and place,	and due to	the cause(s)
	To tha within 2. To tha complete	Ž	29b. Signature and title of certifier	00		29c. License	e number		29d. Date signed	(Month,	Day, Year)
	12		Cut W. O.	Wegn M.	D-	D39	7177		MARCH	18	2005
			30. Name and address of person who co								
	-0		31. Date filed (Month, Day, Year)			24 GENE	RAL H	OSPITAL	DLNEY	,/	ND
	Sta Registr	- 1	MAR 2 5 200		K Ass	ules.					

Amend#1 per phy. 3/29/State of Maryland / Department of Health and Mental Hygiene [] [] 5 12245 AACO HEALTH DEPT CMH Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Deeth 3. Time of Death March 22 Dey 2005 Year Physician Olson Anlee 12:15 p. Olson-Reid /Medical 4b. City, Town, or Locetion of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Linthicum Anne Arundel Chesapeake Hospice House 8. Date of Birth (Month, Day, Year) June 21, 1949 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2√2 F 485-56-9531 55 Yrs. Iowa Director Usuel Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at Maryland Anne Arundel Annapolis 1 ☐ Yes 2X No Directo or 28a-f s 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code permit. Peges 1 and 2 should be filed within 72 hours effer death with Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "--- any injury or other traument— any injury or other traument— 21401 United States 199 Severn Drive 238 Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married XX Married 1 ☐ Yes X☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Worker County Government 8 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Roger Olson Doris Humble 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (daughter) 199 Severn Dr. Annapolis, MD 21401 Amanda Sampson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Mar.23, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 2005 22. Name and Address of Facility Advent Funeral & Cremation Services 21. Signature of Fineral Service Licensee M00982 42 Hudson St. Suite 110, Arrapolis, Maryland 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The lew requires that the death certificete be executed use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physicien end Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1_ Yas 2 No 1 ☐ Yes 2 ☐ No r: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA **Tospice** Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Certification: To 1 Yes 2 No HOUSE 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending s efter death.
I Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours of To the Funeral D completely filled in edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 53306 30. Name end-address of person who completed cause of death (Item 23e) (Type, Print) Rd Ste 211 HANDapoles 888 CUFTIS Tarr 31. Date filed (Month, Dey, Year) strer's Signature 32. Rg State Registrar 2005

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of H		-	giene)5	122	46
			1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea	ath	Vana	3. Time of	Death
	Physici /Medi		Joseph I.		O'Co	nnell		Month March	Day 25, 200	Year 05	1:10	рм
)	Examir		4a. Facility Name (If not institution, gr	ve street and number)	4b. City, Town, or	Location of De			y of Death		
			Solomons Nursin	Center		Solo	ກາດກອ		Ca1	vert.		
	Funeral			Sex 7. A	ge (In yrs. last birthday,	If Under 1 Year Months Days	ITONS If Under 24 H Hours M	Hrs. 8. Date of Birt Min. (Month, Da	h		place (State or	r Foreign
	Director		579-10-2507	1 X M 2□F	88 Yrs.			June 7,			ngton,	D.C.
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation				1	0d. Inside Cit	tv Limits
	Aarylan F show	ō									1 ☐ Yes	•
	28a-	Director	DE Susse:	ζ	Dagsbo	10f. Zip Code			10g. Citizen of	What Cour	ntrv?	
	Mith Se or	٥									,	
	na 23	Funeral	111 Creekside]	12. Was Decedent	Ever in U.S. 13.	19939 Was Decedent of His	spanic Origin?	(Specify Yes or No	USA 14. Ra	ce - Americ	an Indian,	
60	r Iter	F.	1 Never Married 2 Married	Armed Forces 1 XYes 2 □	No	If Yes, specify Cubar		uerto Rican, etc.)		ick, White,	etc.	
03	ent', o	b	3√ Widowed 4 Divorced	If Yes, Give Year or Dates:	Unknown	1 ☐ Yes 2 🔀 No	Specify:		Specia	<i>fy:</i> Whi	ite	
21215-0036	72 hours after death with the Maryland natural', or itema 23a or 28a-f show disal Examinat must be nutified at	Completed	15. Decedent's I (Specify only highest g		16a. Dece	dent's Usual Occupa kind of work done d	ition	working	16b. Kind of B			
21	ithin	npie	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired,)					
21	ygier ygier her th	S	12		Polic	e Officer			Law En		ment_	
pug	be fill	Be	17. Father's Name (First, Middle, Las				18. Mother's I	Name (First, Middle,	Maiden Sumai	me)		
7 8	ould Mer narke	P P	Jim O'Conne		405 14:33				Clark	0 7.	0.41	
Maryland	12 st h and 7 is n traun		19a. Informant's Name/Relationship			ng Address (Street a	na Number or	Rural Route Numbe	-		Code)	
e,	1 and Healt em 2		Rose Lee Pendry 20a, Method of Disposition	Daught	20b. Place of Disp	reekside	Drive	Dagsboro,	Delawa: 20c. Location	re 1	9939 own. State	
و	Se of Se of		1 ⊈Burial 2 ☐ Cremation 3		cometent cre	matory`or other place	!					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event, the Medical Evanthat must be notified at ance.		 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic 			emeterv	Ma;	r.30,2005	Silver	Sprin,	g,MO	_
Ba	Depril Impo		VWill Edge		Fr	ancis J.	Collin	s Funeral	Home,	Inc.		
	0.00		23a. Part 1. Enter the disease, or co	nolications that cause	d the death. Do not en	() Univers	ity Bl	vd. W. Si	Lver Sp	ring,	Approximate	9
			shock, or heart failure. List onli Immediate Cause (Final	y one cause on each	line.			. ,			Onset and D	
7	Physician /Medical		disease or condition resulting in death)	a. Stroke	s a consequence of):					_		
в	Examiner				Fibrillatio	n						
	THE PARTY	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Under ving Cause (Disease or injury		s a consequence of):	11						
	cuted	Examiner	that initiated events	C								
oʻ	e exerian ar	EX	resulting in death) Last	Due to (or as	s a consequence of):							
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dicai		d								
9	ing ph	0	IF FEMALE:						1	1		
Вох	leath certific attending pl	an/	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal death 3(Ectopic pregnancy				ate of delive	,	rear
	the all	Physician/M	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	at time of death 5	Other (specify)				Orter	Juy .	ou.
P.0	requires that the death een signed by the atter hould be detached for u	Ph/	Part II. Other significant conditions	contributing to death	hut not resulting in the I	nderhing cause awa	n in Part I	23e Did to	bacco use con	tribute to th	an cause of de	path?
Records,	9 P 6	1 by	Turk is other signment corrections	contributing to count	bat not resulting in the t	inderlying cause give	armir day.		res 2⊠No			
0	w requir been si should	etec										
3ec	m 0 01	Completed						24a. Was		prior to cor death?	psy findings a mpletion of ca	ivailable iuse of
alF	Thate are			· · · · · · · · · · · · · · · · · · ·				1 ☐ Yes		1 Yes	2 🗆 No	
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	-7	othe Othe	·P	Death (Check only o				
of	교 문 절	. To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Inj		IL SELDON	4 14012111	g Home 5 Resid			y)	
on	ding Ph h. After th funeral	tion	1 X Natural 5 ☐ Pending	(Month, D	ay Year) Injury	Work	? ′es 2 □ No					
Division	r Attending er death. rector: After by the fune	fica	3 Suicide 6 Could not	be and Place of In	njury - At home, farm, st			28f. Location (S		ber or Rura	I Route Numb	ber,
Div	after Dire	Certification;	4 Homicide	building, e	tc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Tox	m, State)			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the				t of my knowledge, dea							
	ne Ho n 24 l ne Fu	edicai	(Check only 2 Medical Exa	iminer: On the basis and manner s	of examination and/or in tated.	vestigation, in my op	inion, death o	ccurred at the time,	date and place,	and due to	the cause(s)	
	To the To the Comp	M	29b. Signature and title of certifier	010		29c. License	number		29d. Date signe	ed (Month,	Day, Year)	
	1		1 Don	If had	-0 KM	ת ת	7810	М	arch 25	, 200)5	
	7		30. Name and address of person	completed cause of	death (Item 23a) (Type							
			David Tardio, M	100000	Hospital R		Prince	Frederic	k,Maryl	and	20678	
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 8	2005 32. Tegist	trar's Signature	cells?						
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			For State	State of Ma		id / Depa	artme		lealth and	-	giene	2005	1001-
/1	iysicia Medic kamin	al	1. Decedent's Name (First, Middle, Las Leonard S 4a. Facility Name (If not institution, give	hull	Po	oland			r Location of Dea	2. Date of De Month	Day	Year Ounty of Death	3. Time of Death
Fur	neral ector		214-07-2100	7. Age	1 + c (In yrs. 19	last birthday) Yrs.	If Un Monti	der 1 Year	If Under 24 Hrs Hours Min	8. Date of Bi	th Year) I, 191	6 9. Birth	pplace (State or Foreign
e Maryland	tified at	ctor	Usual Residence of Decedent 10a. State 10b. County WV Minera		10c. Cit	y, Town or Lo Wiley		rd					10d. Inside City Limits 1 Tyes 2 No
sath with th	nual be no	Funeral Director	Route 1 Box 2	10 Was Dassidani		0 140.1			26767			en of What Cor	
5-0036 72 hours after death with the Maryland natural; or Items 23a or 28a-f show	Examiner	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent & Armed Forces? 1. Yes 2 □ N If Yes, Give Year or Dates:				s 2 No	Ispanic Origin? (: in, Mexican, Puel Specify:	Specify Yes or No rto Rican, etc.)		4. Race - Amer Black, White Specify: Whi	e, etc.
21215-0036 ad within 72 hours aff glene. er then "natural", or	or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5	+)	16a. Deced (Give life. I	kind of DO NO	Isual Occup work done of Tuse retired	ation during most of wo f)	orking	16b. Kind	of Business/I	ndustry
Maryland 2 Id 2 should be filed to the and Mental Hygle 27 Is marked other	natic evant,	To Be C	17. Father's Name (First, Middle, Last) Granvil R. Polan					4-	Anna	me (First, Middle (Cooper)	, Maiden S Polai	oumame) nd	
iore, Mariges 1 and 2 short of Health and 18 mg.	har traun		James Ganoe	^{Гурө, Print)} nephe		Rout	te 1	Box 5	A		Ford	W	V 26767
P Pa	jury		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify 21. Signatur® of Funeral Service Licen)		Place of Dispo cemetery, crem ee Churc	ches	Cemet	ery	3/19/2005		ee Chur	ches WV
Balti Permit, Depertm Importa	any le		23a Part Enter the disease, or comp	ALL	UU the deat		1	08 Virg		e: Cumbe		MD 21502	Approximate
	dical		should, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	one cause on each lin	Pro.	ton.	1	e les 2					Interval Between Onset and Death
1760, te be executed with a second se	ourial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Poly Due to (or as: c. Out to (or as: d.	ue	obs tr	U(l teve ;	to need	moree	CZ: NEOS		J W/D J ylan
o g g	detached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	ildeath 3□		pregnancy (specify)			23	Bd. Date of delin	very Day Year
Records, P. The law requires that the has been signed b	should be deta	by	Part II. Other significant conditions of	ontributing to death bu	it not res	ulting in the u	nderlyin	g cause giv	en in Part I.		_		the cause of death?
	page 2	Completed								24a. Was auto perfe 1 Yes		prior to c death?	opsy findings available ompletion of cause of
	funeral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpatie	v	ER/Outpatien 28b. Time of Injury		DOA Oth-	er: 4 🗌 Nursing I	ath (Check only Home 5 ☐ Res 28d. Describe	dence 6		ify)
Signal of	ed in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	iry - At h	ome, farm, str	eet, fac	tory, office		28f. Location (City or To		Number or Ru	ral Route Number,
he Hospital in 24 hours a	pletely fill	edicai	29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ☐ Medical Exam	vsician: To the best of iner: On the basis of and manner sta	examina	owledge, death	h occurr vestigat	ed at the tin ion, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
To the Vithin 2		2.	29b. Signature and title of certifier	منعصف		W		29c. Licens	e number 8377			signed (Month	-
D.	165		30. Name and address of person who Dr. Uriel Velan	completed cause of de	eath (Iter			Drive	e, Suite	# 303			nd, MD2151
R	Sta egistr	- 1	31. Date filed (Month, Day, Year) MAR 2 2	32. Registra 2005	ar's Signa	ature /	102	I.					

DHMH 17 Rev 1/2001

			1 - For State Registrar			nd / Depa	artment of h	lealth a		tal Hygier	ne 2 0 0	5 10010
			Registrar 1. Decedent's Name (First, Middle	Lacti		Ce	rtificate of	Deam	125	Reg. No	40. C. U U	J 16640
	Physicia	an	Sarah Pod						1	Month E	Day Year	
	/Medic		4a. Facility Name (If not institution		herl		4b. City, Town, o	or Location of		RCH 21,	2005 tc. County of De	12:15 P M
	Examin	er	HEBREW HOME OF (ON	ROCKVILI		Death		ONTGOMER	
	Funeral		5. Social Security Number		. Age (In yrs.		If Under 1 Year	If Under 2	24 Hrs. 8. C	Date of Birth		irthplace (State or Foreign Country)
	Director		065-38-3378	1□M 2XF	9	93 Yrs.	Months Days	Hours	Min. 08	Month, Day, Yea /07/191:		SSIA
	D .		Usual Residence of Decedent		10- 02						, , , , , ,	
	anyla shov	'n	10a. State 10b. County		100. CR	ty, Town or Lo	ocation					10d. Inside City Limits 1XYes 2 ☐ No
	he M	Director	MARYLAND MONTGO	MERY	ROCI	XVILLE	1,01,71,0,1					
	with 1	Ö	10e. Street and Number	A.D.			10f. Zip Code			10g. (Citizen of What (ountry?
	eath	Funerai	6121 MONTROSE RO	JAD 12. Was Deced	lent Ever in II	S 13	20852		in? (Specify	Voc or No.	U.S.A.	
-	iter d	Fun	1 Never Married 2 Marri	Armed Ford	eş?		Was Decedent of H If Yes, specify Cub		Puerto Rica	n, etc.)	Black, Wh	
ဗ္ဗ	al', o	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Da			1 ☐ Yes 2 🛣 No	Specify:			Specify:	WHITE
o O	filed within 72 hours after death with the Maryland Hygiene. sthar than "natural", or Itams 23a or 28a-f show ant, the Madical Exertitual to multihed at	Completed by	15. Decedent (Specify only highes			16a. Dece	dent's Usual Occup kind of work done	oation	of working	16b.	Kind of Busines	s/Industry
21215-0036	ithin	nple	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use retire	d)	or working			
7	ed wi	S	12			HOME	MAKER				VN HOME	
Ē	be fill tal H id oth	Be	17. Father's Name (First, Middle,					18. Mother	r's Name (Fir	st, Middle, Maide	en Sumame)	
3	should be nd Mental markad c	_C	DAVID	GURE	NITZ	105 14-05	Add (Ct	ANNAF				ERTAINABLE)
Maryland	C1 62 62 62		19a. Informant's Name/Relationsh DAVID PODOFF/SON				ng Address (Street					
<u>ئ</u>	1 and 1 Health tam 27 sthar tr		20a. Method of Disposition		20b. F	Place of Dispo	HOLLOWST		Date		MD 208 Location - City of	
Baltimore,	Pages nent of h ant: If its		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		iate	-	matory`or other pla		. / 0.0 / 0.4			
₹	permit. Page Department Important: If any injury or once.		21. Signature of Euneral Service I		[301		EM. GARDE		3/23/20		IEY. MAR	YLAND
ä	permii Depar Impos any ir once.	1 3		2/2	-	1 EL	Name and Address WARD SAG 191 ROCKV	EL FUN	NERAL I	DIRECTIC	N, INC.	0852
		_	23a. Part1, Enter the disease, or shock, or heart failure. List	complications that ca	used the deat						<u> </u>	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	PNEUM(Onset and Death
1	/Medical		resulting in death)	a	ras a conseq	uence of):						2 WEEKS
	Examiner		Sequentially list conditions	b. DYSPHA	AGIA							2 MONTHS
1	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	r as a conseq	uence of):						
	and and trans	Examiner	that initiated events resulting in death) Last	c. DEMENT	TA r as a conseq	uonos of):						6 YEARS
760,	te be executed ysician and te burial-transit	calE			1 a3 a conseq	derice or).						
687	y de			d								
×	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc							23d. Date of de	elivery
.O. Box	death certifica e attending ph id for use as th	Physician/Med	in the past 12 months?	4□Pregna	th 2 ☐ Feta nt at time of d		Ectopic pregnancy Other (specify)	/			Month	Day Year
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Ś	w requires that been signed k should be det	ру Р	Part II. Other significant condition	ns contributing to dea	th but not res	ulting in the u	nderlying cause giv	en in Part I.	:			to the cause of death?
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<u>~</u>		Con								performed? Yes 2X1∧	death?	s 2 No
Vital	nysiclan: Th nis certificate director, pag	Be (25. Was case referred to medical examiner?							eck only one)		
) t	g 5	2	1 ☐ Yes 2 X No			ER/Outpatier	t 3 DOA	er: 4X Nurs		5 Residence		ecify)
Division of	Attending Physiclan: r death, ector: After this certific by the funeral director,	lon	27. Manner of Death 1 X Natural 5 ☐ Pending		Day Year)	28b. Time of Injury	Wor	k?		Describe how inj	ury occurred	
<u>s</u>	death death stor: / the	icat	2 Accident investig	ot be	f Injury - At he	ome farm et	eet, factory, office	Yes 2□N	-	ocation (Street:	and Number or E	Rural Route Number,
<u>></u>	lor A after Direction by	Certification;	4 Homicide determine	building	, etc. (Specif	y)	eot, raciory, omco			City or Town, Sta		iorar Houte Wantber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral		29a. Certifier 1 X Certifyin	g Physicien: To the b	est of my kno	wledge, deati	occurred at the tir	ne, date and	place, and d	lue to the cause(s) and manner a	is stated.
	24 h	edicai	(Check only 2 Medical I	Exeminer: On the bas and manne	is of examina	tion and/or in	vestigation, in my o	pinion, death	n occurred at	the time, date a	nd place, and du	e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	10			29c. Licens	e number		29d. D	ate signed (Mor	th, Day, Year)
•	1		1-5C15	, KU		- m	me	370	464	м	ARCH 21	2005
	5		30. Name and address of person v	who completed cause	of death (Item	n 23a) (Type,	Print)	1 0	1 41		, ,	
			Ens E Ka	hn, m	6(2)	mon	Print) Prose Rose	k Ko	xkulle	y mary	land	•
	Sta Registr		31. Date Med (Month, Day, Year) MAR 28	2005 Z. R.	gistrar's Signa	IUF9	de la			J	,	
		41	mnix ~ 0	MARIE								

State of Maryland / Department of Health and Mental Hygien For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:40PM **Physician** 20,2005 MARCH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number, Examiner Montgomery Rockville Hebrew Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 09/15/1932 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral №** M 2□F 72 Washington, DC Director 577.40.4686 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 'natural', or Items 23a or 28e-f show or other traumatic event, the Mudical Examiner must be notified at 1 Yes 2 □ No Director Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3713 Chevy Chase Lake DR. # 3 20815 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. a filed within 72 hours after dail Hygiene. Other than "natural", or Item 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Developer Real Estate permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Importent: If Item 27 Is marked other? Any injury or other traumatic event, If the permits of the traumatic event, If the permits in the traumatic event, If the permits in the traumatic event, If the permits is the permits in t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Milto Panagos Evodokia Kouis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Panagos / Daughter 3713 Chevy Chase Lake DR. #3, Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/25/05 Brentwood, MD Ft. Lincoln Cemetery 22. Name and Address of FacilityJoseph Gawlers Sons Inc. 21. Signature of Euneral Service Licens 5130 Wisconsin Ave. N.W., Washington DC 20016 MO1378 Kanes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): TONGUE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2/2 No certificate 1 ☐ Yes 2 XNo 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation within 24 hours after death.

To the Funeral Director: A 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tipe of certifier 29c. License number D 35436 HARCH 20, 2005 3 Barbara Kalaznym M.D. 31. Date filed (Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end item 3 per doc 8842 4-11-05 vt. State of Maryland / Department of Health and Mental Hygiene 12250 State Registrar amended 3-25-05 item #26/wch@patificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12:45a 05 Raymond V. Purnell 2005 March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** M 2□ F 81 Yrs. 212-18-6920 Nov 19, MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rai', or items 23a or 28a-f show Examiner ount be notified at 1√2 Yes 2 □ No MD Director Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 10604 Flower St. 21811 U.S. by Funeral 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Never Married 2☐ Married 1 Tes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Black Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural" al Hygiene.
d other than "natural
avant, the Madical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public School Bus Contractor 10th 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked 2 Charles E. Purnell, Sr. Blanche E. Predeaux 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joshua Pitts/son 4250 Spire Ct., Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If Its any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Paul UMC Cemetery 3/12/2005 Berlin, MD 21. Signature of Funeral Service Senses 22. Name and Address of Facility Lewis N. Watson Funeral Home 23a. Part. Expert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final interction Mydeerdial **Physician** minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Year ٥ Month Day 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by рe 1 Yes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 1 ☐ Yes 2 ☐ No certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home—5 Residence 6 Other (Specify) 2 No 3□ DOA 1 Yes this 28c. Injury at Work? in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Momicide To the Hospitel
within 24 hours a
To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud Suste 1 Barin Md 2/8/1 Peter S Abbitt MO 10445 Ocean Cay

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 2 5 2005

32. Registrar's Signature

an cal	Stata Registrar Decedent's Name						epartme					201	1 (1000
an cal	Decedent's Nam	/=:	4 .1				ertitic	ate of	Death	10.000	Reg. N	6 0	7.0	1660
4	WILLIA		$_{ ext{NLOI}}^{ ext{Last}}$	ם כ	TRUCE	7				2. Date of D	eath D	ay _	Year	3. Time of Dea 19:21
42.	Facility Name (I						4b. C	itv. Town. o	or Location of Deatl		000	c. County	05 of Death	11.011
5	ocred Social Security N	Hea	17 6. Sex	Hos		s. last birtho	fay) If Un	LLM der 1 Year	If Under 24 Hrs.	8. Date of B	irth	A //	egg 9-Birth	lace (State or Fo.
Us	220-34-		1 🕅 N	/ 2□F	66	Yrs	Monti	ns Days	Hours Min.	SEPT •	3,19	38	Coui	YLAND
10	a. State	10b. County			10c. 0	City, Town o	r Location						1	10d. Inside City Li
0	MD		GANY	<u> </u>		CRESAF		~ ~ .						1 Yes 2
100	e. Street and Nu $12706{ m D}$		71 T. T. T. T. T. T. T. T. T. T. T. T. T.	пте			101.	Zip Code 21502)			itizen of W J.S.A		ntry?
e 11	. Marital Status	AKKOWS		Was Dece	dent Ever in	U.S.	13. Was De			pecify Yes or N				can Indian,
by Fun	1 Never Marr		ied	Armed Fo 1 Tes If Yes, Giv Year or Da	2. [2] .No ′e			specify Cubi 2 $\overline{\mathbf{X}}$ No	dispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)			k, White,	
ted	10	15. Decedent	t's Educa	tion		16a. D	ecedent's L	Isual Occup	pation		16b.	Kind of Bu		
Completed	Elementary/Seco	ondary (0-12)	st grade o	College (1	-4or 5+)		fe. DO NO		during most of word) ATOR	rking	E	BAKER	Y	
a) 17.	. Father's Name	(First, Middle,	Last)						18. Mother's Nar	ne (First, Middi	e, <i>Maid</i> e	n Surname	э)	
To B	WALTER	E. RC	TRUC	CK					BLANCH	Е Е.	TAYI	O R		
19	a. Informant's N BARBARA	_							and Number or Ru STREET,					
20	a. Method of Dis 1 Burial 2	Cremation		noval from	State	-	crematory (or other pla		Date 2005		ocation -		
2'	* 4 □Donation . Signature of Fu	-			RI	STLCS			RDENS 03/		-	AVALI	E, M	D .
	Mary	1/0	9.	20/100	ind)				SS of Facility I FUNERAL					21.502
2:	3a. Part1. Enter t	h disease, or	complica	ations that c	aused the de	ath. Do not			ONE STREET			MD, I	MD ,	21502 Approximate
di	snock, or nea nmediate Cause sease or condition sulting in death)	art failure. List (Final on	a.	_	RDIA	C	FAL	LUR	E					Interval Betwee Onset and Deat
			1	Aart	or as a cons	equence of)	Ston	7515	+- Goro	nary f	rto	ry 7)	SAA	₹ <i>1</i> 7
Se if	equentially list co any, leading to in use. Enter Unde ause (Disease or	nditions, nmediate	b. 1	Due to (or as a cons		<i></i>	JU1-	· 401 01	i dy i	17.0	, V		
This is	at initiated events	S	٥. (ry Art			e						
	sulting in death)	Lasi		Due to (or as a conse	equence of):	•				17	/)		
dlca			d							10	16	26-1	MATEC	125,200
	FEMALE: 8b. Was decedent in the past 12		230	1 Live b	come of preg	tal death	3 □Ectopi		у		CU	23d. Date		
ysic	1 ☐ Yes 2 [9 ☐ Unknown			9☐ Unkno	ant at time of own	death	5 Other	(Specify)						
کُو اِرْ	rt II. Other signi	ficant conditio	ons contri	ibuting to de	ath but not re	esulting in th	ne underlyir	ig cause giv	ven in Part I.		tobacco		ibute to th	ne cause of death
lete										24a. Wa	s an	24b. W	Vere auto	psy findings avail
Completed										auto per 1 🗆 Yes	opsy formed? 2 N	d	rior to co eath? □ Yes	mpletion of cause 2□ No
9 25	. Was case refer	red to medical	Uas	anital.				04	26. Place of Dea	ath (Check only	one)			
۵_	1 Yes 2□	No	Hos		·	ER/Outpa		DOA Oth	4 🗀 Nursing H	lome 5 Res				y)
Certification:	. Manner of Deal Natural Control Accident	5 🗌 Pendin investig	gation	28a. Date of (Mont	th, Day Year)	28b. Tim Inju		28c. Injur Wor 1 🗆	ry at rk? Yes 2 □ No	28d. Describe	now inju	ary occurre	90	
Sertific	3 ☐ Suicide 4 ☐ Homicide	6 Could r determ		28e. Place buildir	of Injury - At ng, etc. <i>(Spe</i>	home, farm cify)	, street, fac	tory, office		28f. Location City or To			er or Rura	al Route Number,
	Pa. Certifier (Check only one)	Certifyin 2 Medical	g Physic Examina	r: On the ba	best of my k asis of exami ner stated.	nowledge, d nation and/o	leath occur or investigat	ed at the tir	me, date and place opinion, death occu	, and due to the	e cause(, date ar	s) and mar nd place, a	nner as s nd due to	tated. the cause(s)
ਰ	b. Signature and	title of control	-					29c. Licens						Day, Year)
	b. Signature and	1111						11/1/	4 1 1 Am 6		444	_ /_		W V 14
≥ 29	1	NU	7				•	טטע:	56575		Ma	rcn	27	, 200:
× 29	Name and addr Mar Date filed (Mon	12/1/01	1300	2.91	e of death (It	em 23 <i>a</i>) (Ty	rpe, Print)	100 l	56355 Jumber	land M	MA 13	irch 21	50°	

			1 - For State Registrar		of Marylan		artmen rtificate			and M		Rag. No.	0000	<u> </u>	2252
н	Physici	an	Decedent's Name (First, Middle, La	ast)						:	Date of De. Month	ath Day	Yea	3. r	Time of Death
	/Medic	al	Mabel Mabel		uerite		Robert				March 2		005		LO:10 A M
	Examin	er	4a. Facility Name (If not institution, gi		imber)		4b. City,		Location o			40.	County of De		
	Funeral		301 E. Reynolds 5. Social Security Number 6.	Sex	7. Age (In yrs.	last birthday)	If Under		mberla If Under		8. Date of Bir	th	A11e		(State or Foreign
Н	Funeral Director			1 □ M 2 ဩ F	84	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 08/30/1	y, Year) 920		Country) rylan	(State or Foreign
			Usual Residence of Decedent								00/30/1				
	arylar show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation								Inside City Limits
	8a-1s	Director	MD Alle	gany		Cumb	erland								1 ☐ Yes 2 ☐ No
	vith th	Dire	10e. Street and Number				10f. Zip					10g. Citi	zen of What	Country?	
	s 23s	rai	301 E. Reynolds			0 100		2150		. 0.10	7 17		USA		
	Itam Itam	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed F	cedent Ever in U orces? 2☑No	.5.	f Yes, spec	ent of His	n, Mexicar	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	•	14. Race - An Black, Wi		ndian,
336	ours after death with the Marylan rat', or Itams 23a or 28a-1 show Examiner : wat be notified at	by	3 ☐Widowed 4 ☐ Divorced	If Yes, G	ive '		1 ☐ Yes 2	2DXNo	Specify:				Specify:	White	e
21215-0036	172 hours after death with the Maryland "neturel; or Itams 23e or 28e-1 show defeal Examinate: ust be nullited at	ted	15. Decedent's E			16a. Deced	dent's Usua	I Occupa	tion			16b. Ki	nd of Busines		
215		Completed	(Specify only highest gi		(1-4or 5+)	life.	kind of wor DO NOT us	se retired)	uring mos	t of worki	ng				
2	77	Con	12			<u> </u>	Homema	ker					Homem	aker	
Ind	d tal	Be	17. Father's Name (First, Middle, Las	t)					18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)		
Maryland	should be and Mental marked o	2	Earl	T 510	St	mith		15.	Mary		Elmi			urtz	
Mai	12 1 13 1 14 1 15		19a. Informant's Name/Relationship John E. Robertson				•				il Route Numbe imberland				(e)
	1 and Healt am 2 ther		20a. Method of Disposition	1 / 5011	20b. F	Place of Dispo	sition (Nan	ne of	T	,	Date		cation - City of	_	State
ē	0 0		1 Ø Burial 2 ☐ Cremation 3 [State	semetery, cren nset Mem	natory or o	ther place)3/22/	/2005				
Baltimore,		1	 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice 		Su						ams Famil		erland,		
Ba	permit. Departr Importa any inju		tohert C	ada	ma		404	Decat	ur Stı	reet,	Cumberla	nd, M		,	• * * * * * * * * * * * * * * * * * * *
	Physician	2 H	23a. Part1. Enter the disease, or con shock, or heart failure. List only immediate Cause (Final disease or condition	nplications that one cause on	caused the deat each line.	h. Do not ent	er the mod	e of dying	, such as	cardiac o	or respiratory a			Inte	proximate erval Between ser and Death
	/Medical Examiner		resulting in death)	aDue to	(or as a conseq	uence of):					Cer ju	1			onco-
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	uence of):									
	be executed sician and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	C.											
ó	an an irial-tr		resulting in death) Last		(or as a conseq	uence of):									
8760,	cate be	ica		_ d.											
<u>8</u> 9 ×	e as t	Med	IF FEMALE:												
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No.	1☐Live	itcome of pregna birth 2 ☐ Feta nant at time of d nown	I death 3	Ectopic pro Other (sp					2	23d. Date of d Month	elivery Day	Year
σ.	that the the the the the the the the the th	by Ph	Part II. Other significant conditions	contributing to	ieath but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	obacco u	se contribute	to the ca	use of death?
rds	w requires been sign should be										1 🗆 1	/es 2[4 No 3□1	Probably	4 Unknown
Records,	e law re has bee je 2 sho	ompieted									24a. Was		24b. Were prior to death	complet	findings available tion of cause of
a		0									1 ☐ Yes	2 No		s 2 🗆	No
Vital	Physician: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner?	Hospital:		55/0		Othe			(Check only o				
of		\vdash	1 ☐ Yes 2 ②No 27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of		8c. Injury	at		me 5 X Resid 28d. Describe h			ecity)	
ion	Attanding I r death. actor: After by the funer	atio	1 Patural 5 Pending 2 Accident investigation		nth, Day Year)	Injury	М	Work	? ′es 2 🔲 I	No					
Division	spital or Attandi burs after death. leral Director; A filled in by the fu	Certification:	3 Suicide 6 Could not determined	286. Plac	e of Injury - At ho ling, etc. (Specif	ome, farm, str	eet, factory	, office		1	28f. Location (S City or Tow			Rural Rou	ute Number,
	(V) To the Hospital or A within 24 hours after To tha Funeral Directomplately filled in by	edical (29a. Certifier 1 Cartifying P (Check only one) 2 Medical Exa	miner: On the I											
	To the within To the comp	Me	29b. Signature and title of contition	,/			29c	. License	number			29d. Date	e signed (Moi	nth, Day,	Year)
•	3		· /M	1ago	ner	m		D22	181			Mar	ch 22,	2005	
	na		30. Name and address of person who Gary L. Wagone:	//	se of death (Item 925 Bish			. Cum	berlar	nd. Ma	rvland	21502			
	Sta Registr		21 Date filed (Month) Bally Vateria		Registrar's Signa	ature,	and de		2.00		J20				

		4	For State	State of Maryla		artment of I			9	005	LOOPA
			Registrar	-41		uncate of	Dealii	2. Date of Dea	Reg. No	UUU	3. Time of Death
	Physicia		Decedent's Name (First, Middle, La		erine	D	uppert	Month	Day	Yeer	00:40 M
	/Medic		LaVerne 4a. Facility Name (If not institution, giv		erme		or Location of Death	0.5		ounty of Death	00 .0
	Examin	er	Secred Har	art Wasdi	tal	Cim	benlan	12	A	11290	UN
	Funeral				rs. last birthday)	If Under 1 Year Months Days		8. Date of Birt (Month, Da	h Year)	9. Birthi	place (State or Foreign
	Director		213-12-9792	1□M 2\ F 84	Yrs.	Months Days	Hours Will.	10/03/19	20		sylvania
7	2	⊦	Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	ocation					10d. Inside City Limits
200	shoy		10a. State 10b. County MD Allega			mberland					1 ☐ Yes 2X No
2	28a-f	Director	10e. Street and Number	,		10f. Zip Code			10g. Citize	on of What Cou	ntry?
di.	a or	古		lew Road, N.E.			21502			USA	
prelyreM eth Him Head	o within 72 flours eller death with the way hair glade. Then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of	Hispanic Origin? (Sr	ecify Yes or No	- 14	. Race - Ameri	
0	ir the		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		1 ☐ Yes 2 ☐ No	oan, Mexican, Puerto Specify:	Hican, etc.)		Black, White	, etc.
5-0036	at', o	by	3 Midowed 4 Divorced	If Yes, Give 11 Year or Dates:		ILI TOS ZLAINO	Specify.			ipecify:	White
1215-0036	natul	Completed	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occu kind of work done	during most of worl	king	16b. Kind	d of Business/Ir	ndustry
5	han Fan	ld m	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retir			Nii	rsing Ho	me
V 3	Hygier Other th		17. Father's Name (First, Middle, Las.	1)	Nul	rsing Assis	18. Mother's Nam	e (First, Middle,			
anc	<u> </u>	Be	Grover	Peter	Bri	idges	Rosalia	(NM	N)	Donah	oe
Maryland	es 1 and 2 should be 1 of Health and Mental I i itam 27 is marked or rother traumatic eve	2	19a. Informant's Name/Relationship				at and Number or Ru	ral Route Numbe	er, City or	Town, State, Zi	p Code)
E S	Ith and 27 is 27 is trau		Roseann Bennett / d.		1230	05 Gap View	w Road, N.E.	, Cumberl	and, M	nD 21502	
စ် :	Health tam 27 othar to	H	20a. Method of Disposition	20	b. Place of Dispe			Date		ation - City or T	
2	Pages net of int: If it		1 🖾 Burial 2 ☐ Cremation 3 [14 ☐ Donation 5 ☐ Other (Special Content of the co			morial Par		3/2005	Cumb	erland,	MD
	permit. Page Department of Important: If any injury or once.	1	21. Signature of Funeral Service Lice		2	2. Name and Add	ress of Facility	dams Fami	.1y Fur	neral Hom	e, P.A.
m	Deg E G		Lohat C. ad	em			atur Street,			21502	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the c	leath. Do not en	ter the mode of dy	,	j.			Approximate Interval Between Onset and Death
F	ากงระเวลก	2	Immediate Cause (Final disease or condition	Acute	My	elugen	14	ukeni	a		dayear
	/Medical		resulting in death)	Due to (or as a con	sequence of):	,					J
	Examiner	L	Sequentially list conditions,	b							
	sit ad	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence oi).						
	law requires that the death certificate be executed as been signed by the attending physician and a should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a con	sequence of):						
8760,	sician Sician			d							
687	ficate g phy: is the	Physician/Medical									
Вох	leath certifica attending ph I for use as t	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I		□Ectopic pregnar	icv		23	3d. Date of deli	
m ·	death e atte	lcla	in the past 12 months? 1 ☐ Yes 2,☑1No	4 Pregnant at time		Other (specify)				Month	Day Year
D. O.	at the by th tache	hys	9 Unknown					220 Did	abassa us	o contributo to	the cause of death?
S,	res that the dei signed by the a I be detached f	by F	Part II. Dther significant conditions	contributing to death but not	resulting in the	underlying cause (given in Part I.		Yes 2		bably 4 Dunknown
ord ord	w requir been si should	ted							-		
of Vital Records,	law r nas be e 2 sh	Completed						24a. Was		prior to o death?	topsy findings available ompletion of cause of
E	sician: The lay certificate has rector, page 2	Cor						1 Tes	2 10	1 🗆 Yes	2 No
/ita	Physician: this certificanal director,	Be	25. Was case referred to medical examiner?	Hospital:		-7-0.	26. Place of Dea			Clother (Cons	(A.)
of	Phys this al dir	7	1 Yes 2 No 27. Manner of Death	1 Inpatient	2 ER/Outpatie	of 28c. In	jury at	lome 5 ☐ Res 28d. Describe			ary)
no	ding I h. After funer	tion	1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Yea	ar) Injury		lork? □Yes 2□No				
Division	I or Attanding after death. Diractor: After I in by the fune	Certification:	3 Suicide 6 Could not	be 28e. Place of Injury -	At home, farm, s	treet, factory, offic	е	28f. Location	Street and wn, State)	Number or Ru	ral Route Number,
Ö	al or A s after il Dirac	Sert	4 Homicide	building, etc. (S)	эөспу)			0.0, 0.7 1			
	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funaral Diractor: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying I	Physicien: To the best of my eminer: On the pasis of exa	knowledge, dea	ath occurred at the	time, date and place	a, and due to the	cause(s) a	and manner as place, and due	stated. to the cause(s)
	in 24 the Fi	edical	one)	and mainer stated.						signed (Montl	
		Σ	29b. Signature and title of certifier		_		nse number			_	6,2005
,	4		Vile	m/2			56766	4-1-1			
	715		30. Name and address of person wh	completed cause of death	(Item 23a) (Type	OU CLOTA	Drive	Combe	lawa	J, MD	21502
		tate	31. Date filed (Month, Day, Year)	32. Regi g rar's S			- WIIVE				
	Renis		MAR 2	8 2005	co M	front !					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3 2145 2005 Edgar Ramsey Lambert 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Garrett County Memorial Hospital Oakland Garrett 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Deys Months Hours 89 217-10-4429 04/02/1915 Maryland Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Mineral 1 ☑ Yes 2 ☐ No Ridgeley 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code Route 1 Box 217A 26753 USA 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Tyes 2 No 1944-If Yes, Give Year or Dates: 1946 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify 3 ☑ Widowed 4 □ Divorced 1946 White Decedent's Usual Occupetion (Give kind of work done during most of working Iffe. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Foreman Tire and Rubber 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cecil Zeddy Ramsey Ethel Friend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Route 1 Box 217A, Ridgeley, West Virginia 26753 Thomas P. Ramsey, Sr. / son 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Vet Cem @ Rocky Gap 04/04/2005 FIRESLOW, 122. Name and Address of Facility Adams Family Funeral Home, P.A. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 404 Decatur Street, Cumberland, Maryland 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DNEUMONIA Due to (or es e consequence of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth?

Physician /Medical Examiner

attending physician and for usa as the bunal-trensit

ed by the a

efter death. Director: Attar this certificete has t d in by tha funeral director, pege 2 s

or Attending Physician:

The law requires that the death cartificate be axecuted

Division of Vital Records, P.O. Box 68760

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

edicai

29a, Certifie

permit. Pages i end 2 should be file Depertment of Health end Mantel Hy Important: If Itam 27 Is marked oth any Injury or other traumatic event

Physician

/Medical

Examiner

Directo

Funeral

Be Completed by

10a. Stete

WV

Funeral

Director

should be filed within 72 hours after death with the Manylend of Manlel Hyglena. marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

e given in Part	orlying cause	underly	in the	resulting	death but no	ons contributing to	ant conditions	Other eignific	Part II.
1		1 2			-		1		

Macrocy tic anemia, diabetes typest

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Death Naturel 5 Pending

2 Accident investigetion 3 Suicide 6 Could not be determined 4 Homicide

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Dey Year) 28b. Time of

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Other:

28d. Describe how injury occurred

1 🗆 Yes

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

21 No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steted.

I medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner steted.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Yeer)

1 ☐ Yes 2 ☐ No

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) KAISER MI

31. Date filed Month, Day, Year) 3

gistrer's Signature 0 2005

State Registrar

ILIVA

NLS

complately filled in by

24 hours Hospital

To the Within 2 To the

			For State		State of Ma	ryland .	-	rtment of H		Mental Hy	la	000		2255
o.			Registrar 1. Decedent's Name (F	īrst, Middle, Last)				incato or i		2. Date of D				Time of Death
	iysici: Medic		Thelma S.	Richards	son					March	24, ^{Day}		12	:00 p. M
	xamin		4a. Facility Name (If no	_				-	Location of Death	n		County of E		
			Kline Hos			"	1:4:4:1	Mt. Ai	ry If Under 24 Hrs.	Ta 0 : (B)		reder		
	neral ector		5. Social Security Numb 422–60–9570	1 🗆	Marke	(In yrs. last	Yrs.	Months Days	Hours Min	8. Oate of Bi (Month, D January	av. Year)		Country)	(State or Foreign nd
and	1220		Usual Residence of De 10a. State 10	cedent b. County		10c. City, T	own or Loc	ation					10d. lr	nside City Limits
Maryl.	a pag	io	Maryland	Frederic	, b	Nova	Marke	t					1	☐Yes 2 PNo
the r 28a	in the	Director	10e. Street and Numbe			New	HALKE	10f. Zip Code			10g. Cit	izen of Wha	t Country?	
th with	भाग		9702 Woodfi	ield Cour	t			21774			U.S	5.A.		
72 hours after death with the Maryland natural: or Itams 23a or 28a-1 show	Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 ☑	22 Married	12. Was Decedent Ender Armed Forces? 1 ☐ Yes 2 ☑ Note of the Note of Page 1. If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - A Black, V Specify:	American In White, etc. White	
	alleg	Completed	15.	. Decedent's Educ only highest grade	cation		(Give k	ent's Usual Occup kind of work done o O NOT use retired	during most of wor	rking	16b. K	ind of Busine	ess/Industry	1
d with	2	Com	Lighter italy/3000110a	ily (0-12)	2	· I -	wner				Pr	intin	g	
should be filed within nd Mental Hygiene.	evant	Be	17. Father's Name (Firs						18. Mother's Nan	, ,	e, Maiden	Sumame)		
i Men	natic	2	Julius (Delan		405 14-15		Joyce K		0:	T 04-	- 7:- O-d	- 1
d 2 strath and 12 strath and 12 strath and 12 strath and 12 strath and 12 strath and 13 strath and 1	traun		19a. Informant's Name Kimberley I						an <i>d Number or Ru</i> d Court,		-			
s 1 and f Health	other		20a. Method of Disposi			20b. Place	e of Dispos	sition (Name of satory or other place	(0)	Date	20c. Lc	ocation - City	y or Town, S	State
Pages nent of its	ıry or		1 12 Burial 2 □ C `4 □ Donation 5 □		emoval from State			Memoria		/2005 1	Emmit	sburg	, Mar	y1and
parmit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important if Itam 27 Is marked other than	any inju		21. Signature of Funer	al Service License	le El	ine	099050	Name and Address	ss of Facility Stumtown P:	tauffer ike, Fr				d 21702
Physi	cian		23a. Part1. Enter the of shock, or heart fa Immediate Cause (Findisease or condition	ulure. List only or	e cause on each line	Э.	Do not ente	-				10.3	App Inter Ons	roximate rval Between et and Death months
	dical		resulting in death)	ſ	Oue to (or as a			LINDING						71011413
	<u></u>	ner	Sequentially list condit if any, leading to imme cause. Enter Underlyir Cause (Disease or inju	ions, bidiate	Due to (or as a	consequen	ice of):							
cate be executed physician and	s the burial-transit	Examiner	Cause (Disease or inju- that initiated events resulting in death) Last			consequen	ice of).						_	
be ey	buria	al E			200 10 (0) 43 4	oonsoquon								
ficate	s the	edical												
To the Hospital or Attanding Physician: The law requires that the death certificate hours after death. To the Fundant Director: After this certificate has been stoned by the attending	ched for use as t	Physician/M	IF FEMALE: 23b. Was decedent pre in the past 12 mo 1 ☐ Yes 2 ☐ Ve 9 ☐ Unknown	nths?	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal de	ath 3 🗆	Ectopic pregnancy Other (specify)				23d. Date of Month	delivery Day	Year
that t	be detached f		Part II. Dther significal	nt conditions cor	tributing to death but	t not resultir	ng in the un	derlying cause giv	en in Part I.	23e. Did	tobacco u	se contribut	te to the cau	use of death?
quires	ald blu	ed by								1 🗆	Yes 2	□No 3[Probably	4 Unknown
The law rectangled has bee	lirector, page 2 should b	Completed										prior	to complete h?	ndings available ion of cause of
cian:	al director, page	Be	25. Was case referred examiner?						26. Place of Dea	ath (Check only	one)			Harrise
hysic	al dire	T _o	1 ☐ Yes 2 No	H	ospital: 1 Inpatien		/Outpatient		4 Nursing H	lome 5 Res			Specify)	House -
ath.	Je U	atlon:	2 Accident	Pending investigation	28a. Date of Injury (Month, Day	Year) 28	Bb. Time of Injury	28c. Injun Wor	y at k? Yes 2 □ No	28d. Describe	now injur	y occurred		
al or Atta	ed in by th	Certification:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Injur building, etc.	ry - At home . (Specify)	, farm, stre	et, factory, office		28f. Location City or To	(Street an own, State		r Rural Rou	ite Number,
To the Hospital or Attendii Within 24 hours after death. To the Funeral Director: A	oletely fille	Medical (sicien: To the best of ner: On the basis of and manner state	examination								
Yo th withir	comp	ž	29b. Signature and title	of certifie				29c. Licens	e number		29d. Dat	te signed (M	fonth, Day,	Year)
	0			~//\		MD	-1.0	029	675		Ma	rch.	25.	2005
. /	و		30. Name and address Roulph 31. Date filed (Month)	V. Bol	mpleted cause of de	1. D.	sa) (Type, F	120 RO	675 OCKledga	e dr.	Be	theso	da,	413.
R R	Sta egistr	- 1	31. Date filed (Month)	AK 2/9 2	UU5	Sal A	A A							

			1 - For State Registrar	State of N		partment of Fertificate of		ınd Mental Hyç	giene	05	12256
	Physicia	an	1. Decedent's Name (First, Midd	le, Last)				2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		CLARENCE HE		****			MARCH	_	2005	1:00P M
	Examin	er	4a. Facility Name (If not institution		•	4b. City, Town, or		f Death		inty of Death	
			FREDERICK M 5. Social Security Number	+	OSPITAL Age (In yrs. last birthda	FREDERI	CK If Under 2	24 Hrs 9 Date of Bird		EDERIC	
	Funeral Director		212-88-2162	1⊠M 2□F	52 Yrs.	Months Days	Hours	Min. 8. Date of Birtl (Month, Day	y, Year)		lace (State or Foreign try)
	ס		Usual Residence of Decedent				1	NOV. I,	1932	wasiii	ngton, DC
	arylar show	-	10a. State 10b. County		10c. City, Town or	_ocation				1	Od. Inside City Limits
	Ba-f	ecto	Maryland Frede	rick	Freder					ļ	1 X Yes 2 ☐ No
	a or	Funeral Director	10e. Street and Number			10f. Zip Code				of What Coun	
	leeth ns 23	era	225 Wyngate 1	12. Was Deceder	nt Ever in U.S. 13	21701 Was Decedent of H	lispanic Orio	jin? (Specify Yes or No-		ed Sta	
ധ	r Iter		1 ☑ Never Married 2 ☐ Mar	ried Armed Forces	s?	If Yes, specify Cuba	an, Mexican	Puerto Rican, etc.)		Black, White,	
ğ	ral', c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:	1 ☐ Yes 2 🔀 No	Specify:		Spe	city: Bla	ck
21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show Ither than "natural", or Items 23a or 28a-f show Int, I've Medical Examinar must be notified at	Completed		nt's Education est grade completed)	16a. Dec	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most	of working	16b. Kind o	f Business/Inc	lustry
12	withir ene. than	mp	Elementary/Secondary (0-12)	College (1-4o	r 5+)		3)		3.7		
о 5	filed Hygid other ent,	o Cc	17. Father's Name (First, Middle,	Last)		None	18. Mother	r's Name (First, Middle,		one	
Maryland	hental hental ked ic ev	To Be	Clarence H. Ro	ouse, Sr.				ilyn Jean S		,	
ary	and N s ma		19a. Informant's Name/Relations	ship (Type, Print)	19b. Mai	ling Address (Street a		r or Rural Route Numbe		wn, State, Zip	Code)
Σ.	and 2 ealth n 27 I	1	Susan Holton/	Personal Re		Research I	rive	Frederick,	Mary.	land 2	1703
Baltimore,	ges 1 If iter or oth		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from Stat	20b. Place of Disp cemetery, cri	osition (Name of ematory or other plac	(e)	Date		on - City or To	
Ē	tment tent: tent:		4 Domation 5 Other (S	Specify)	Clustere	d Spires (aryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other treumatic event, I've Medical Examiner must be notified at once.		21. Si nature d'uneral Service	Licensee		22. Name and Addres		Stauffer F Pike Fred	unera lerick	l Homes , Maryl	s, P.A. Land 21702
			23a. Part1. Enter the disease, of shock, or heart failure. List	r complications that cause only one cause on each	ed the death. Do not e						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Adv	unced !	Cerebral	2 0	alses			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	anced is a consequence of): ynce ()	/ /					
		0	Sequentially list conditions, if any leading to immediate	b. Due to (or a	a consequence of	ho rder					
	uted d ansit	Examiner	Cause (Disease or injury	<							
oʻ	exec en an rial-tra	Exa	that initiated events resulting in death) Last	Due to (or a	s a consequence of):						
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical		d							
39	ing ph e as t	Med	IF FEMALE:								-
Вох	attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy				Date of deliver Month	y Day Year
o.	y the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	at time of death 5	Other (specify)					
<u>a.</u>	res that the de signed by the a be detached t	by Pr	Part II. Other significant condition					23e. Did to	bacco use co	ontribute to the	cause of death?
rds	w requires been sign should be	ed b	Malputn	tem				1 □ Ye	es 2 No	3 ☐ Proba	bly 4 □Unknown
၀ ဂ	e law re has bee	Completed	Clostrid	from Def	hale	Drushen		24a. Was a		b. Were autop	sy findings available
		Mo						autops perform		death?	pletion of cause of
Vital Records,	hysician: The la	Be (25. Was case referred to medica examiner2					of Death Check onl on	e		
10	Physic this c	2	1 0 0 2 No	Hospital: Inpat		nt 3 DOA Othe	er: 4 □ Nurs	sing Home 5 ☐ Reside			
L C	of or Attending F after death. Director: After d in by the funera	lon	27. Manner of Death 1 ■ Natural 5 ■ Pendir		ay Year) 28b. Time Injury	Work	rat ⟨? Yes 2 □ N	28d. Describe ho	ow injury occ	urred	
Division of	Attendi death. ctor: A y the fu	ficat	2 Accident investig	not be	njury - At home, farm, s		105 2 11	28f. Location (St	reet and Nu	mher or Rural	Route Number
2	after I Dire	Certification:	4 ☐ Homicide determ	building, e	etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town	n, State)		Tiouse Humber,
	G 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		29a. Certifier Certifyir	g Physician: To the bes	t of my knowledge, dea	th occurred at the tim	e, date and	place, and due to the ca	ause(s) and	manner as sta	ted.
	To the Hos within 24 ho To the Fun completely	edical	one)	Examiner: On the basis and manner s	of examination and/or it	ivestigation, in my op	oinion, death	occurred at the time, da	ate and place	e, and due to	the cause(s)
	To To Con	Σ	29b. Signature and title of certifie	Verma 1	MO	29c. License				ned (Month, D	
	1		· / jour	oun 1		11-	577	10	Marc	h 19	2, 2005
	1		30. Name and address of person	M D 400			E 1	nd als W	1 0-		
	Stat	te:	30. Name and address of person Lalit Verma, 31. Date filed (Month, Ary, Year)	M.D. 400	death (Item 23a) (Type W. Seventh trar's Signature	Street	Frede	rick, Maryl	and 21		

	/Me Exan
	Funer Directo
NAME ANOWN TO PHISICIAN: BARBARA J. KINEBAKI Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23c or 28a-1 show any injury or other traumatic event, it mentals learn than the month of the property.
w	Pnysicia /Medica Examina
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

For

/Me

		1 - Stata Ragistrer						Ce	rtificat	e of i	Death	7		Reg. N	No.			
		1. Decedent's Name	e (First, Middl	e, Last)									2. Date of D				3. Time	of Death
icia		9	Bar	bara	J. R	ineh	art						Month MARCH)ay 13, 2	Year 2005	11:0	OOA M
dic		4a. Facility Name (II	f not institution	n aive st	treet and nu	ımber)			4b. City.	Town, or	Location	of Death	1		c. County			
nin	er						Mיבור				OINT				CECIL			
		VA MARYLA 5. Social Security N		6. Sex	CARE			st birthday,		1 Year		r 24 Hrs.	8 Date of B				lace (State	or Foreign
al		434-88-5			M 2⊠F		(<i>m y</i> 13. 7.	Yrs.	Months		Hours	Min.	8. Date of B (Month, D May 1	ay, Yea	r) 1944	Cour	Tex	
or		Usual Residence of											May 1	. т ,	1744		167	15
		10a. State	10b. County			- T.	10c. City	Town or L	ocation							1	0d. Inside (City Limits
	5	Virginia	7~~	ling	ton				7	rlin	qton						1 ☐ Ye	s 2⊠No
	ect	10e. Street and Nur		11119	COII				10f. Zip		gcon			100 (Citizen of V	What Cour	ntry?	
	ä				c		-		101. 21		2000			log. (SILIZOTI OT V			
- 1	ra	5017 Sou	ith Che								22206				14 Das	U.S	. A . an Indian,	
	nue	11. Marital Status			2. Was Dec Armed F	orces?		. 13.	If Yes, spe	city Cuba	n, Mexica	rigin? (Sp an, Puerto	ecify Yes or N Rican, etc.)	10-		ck, White,		
	Ę.	1 Never Marri		-	1 XYes If Yes, G Year or [2 □ No		72	1 ☐ Yes	2 🔯 No	Specify	<i>r</i> :			Specify	/: Wh	ite	
	Completed by Funeral Director	3 Widowed				Dates: 1	970-							1	151 1 1 5			
	ete	(Spec	15. Deceden ify only highe	it's Educi st grade	ation com <i>pleted)</i>)		(Give	dent's Usu	rk done	during mo:	st of work	ing	16b.	Kind of Bu	usiness/Ind	dustry	
	du	Elementary/Secon			College ()	///0.	DO NOT u									
	S	unkno			unkn	own			Sec	reta			(F)	14:4		unkno	own	
	Be	17. Father's Name ((First, Middle,	Last)							18. Moth	ier's Nam	e (First, Middle			10)		
	ပ္		Walte:	r Ri	nehar	t							Mar	y Ro	se			
		19a. Informant's Na							•				al Route Numi				_	
		Aimee Saylo	r, Eligi	ibili	ty Cler	k (1	L36A)	V.A.	Maryla	nd He	alth C	Care S	ystem, P	erry	Point	, Mary	rland	21902
		20a. Method of Disp					20b. Pla	ace of Disponentery, cre	osition (Nai	ne of other place	e)	(Date	20c.	Location -	City or To	wn, State	
		1 🔀 Burial 2 [1 4 □ Donation			moval from	State		tico Na				03/2	29/05	Tr	iangl	e, V	irgini	La
oi		21. Signature of Fu			Q .		511	2	2. Name ar	nd Addre	s of Facil	lity						
once.		1/1500	7. h	+	0 447	200	5	Lo	ee A. erryv:	Pat	cerso	n &	Son Fur d 2190			ne, P	.A.	
	-	23a. Part 1. Enter th	ne disease. O	r complic	ations that	caused th	he death.						•		7700		Approxima	ate
Н		shock, or heat Immediate Cause (rt failure. List	only one	e cause on	each line).			,	3 ,						Interval Be Onset and	
n		disease or condition resulting in death)		_ a.	_			PNEUM	AINC								UNKNO	ΝN
al er		,				(or as a												
-	_	Sequentially list con	nditions,	b.				LEFT ence of):	HEMII	PLEG.	LA						UNKNO	NN
	Examiner	if any, leading to im cause. Enter Unde Cause (Disease or	riying 🚄	₹														
	сап	that initiated events resulting in death) I	3	c.		CRTEN (or as a										-	UNKNO	NIN
1	ű l				500.0	(01 23 2	consoqu	01100 017.								1		
	/Medical			d.														
	Me	IF FEMALE:																
		23b. Was decedent	t pregnant	23	lc. If yes, ou 1□Live	itcome of birth 2			∃Ectopic p	regnancy					23d. Dat Mo	te of delive	ny Day	Year
	Sici	in the past 12 1 Pyes 2	No.		4□Preg 9□Unkr	nant at ti	me of de	ath 5	Other (sp	pecify)					1010	*****	Duy	, oui
	Completed by Physicial	9 Unknown				7 11												
	by	Part II. Other signif	icant conditi	ons cont	ributing to o	leath but	not resu	Iting in the u	inderlying o	ause giv	en in Part	I.					ne cause of	
	eq	DIABETES	S MELL]	ITUS									1 🗆	Yes	2 🗆 No	3 Prob	ably 4X]Unknown
	ojet												24a. Wa		24b. \	Were auto	psy findings	available
	E												perf	opsy formed?	'	death?		cause or
	Ö	25. Was case refer	red to medica								26 Place	o of Doot	1 ☐ Yes		40	103	20140	
) Be	examiner?			spital:	V anneigne		R/Outpatie	- 2 D	Oth	0.00		me 5 Res		e □Oth	or (Specifi	d	
	۲.	1 Yes 2X				Inpatient of Injury		28b. Time o		28c. Injur	4 🗀 14		28d. Describe				()	
	lo	1 X Natural	5 Pendir	ng	28a. Date (Mor	nth, Day	Year)	Injury	М	Wor	<br Yes 2.□				. ,			
	icat	2 ☐ Accident 3 ☐ Suicide	6 Could	not be	One Plea	o of Injur	v - At hor	ne, farm, st					28f. Location	(Street	and Numb	er or Rura	I Boute Nu	mher
	E	4 🗌 Homicide	determ	nined	build	ling, etc.	(Specify))	ieel, iaclor	y, onice			City or To			0. 0		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	0		ATT Consider	- Ph		1 1	. Lanci	4-4 - 4 -				- 4 - 4			(-)			
	lica	29a. Certifier Check only one Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
1	27. Manner of Death 1 X Natural 2											Day, Year)						
	_	296. Signature and title of certifier A Aashmi 29c. License number 29d. Date signed (Month, Day, Year) March 13, 2005																
		1010		74	44	سيدات	~ cs	ru	17	4548				/- IU	1CE	ردن	, ~)
		30. Name and address																
•		SHER A. H	HASHMI	M.I)., VA	A MAF	RYLAI	ND HEA	ALTH (CARE	SYST	EM, I	PERRY F	OIN	T, MD	2190	02	

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

MAR 2 8 2005

32. Registrar's Signature

			1 - For State Registrar	State of M		nd / Depa		t of H	ealth a			giene Reg. No. 20	05	1225	58
	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last Lorraine Sylvia 4a. Facility Name (If not institution, give Anne Arundel Med	Raker street and number)	er			Town, or	Location o	of Death	2. Date of Dea Month March	Day 20 4c. County Anne A			M
35	Funeral Director		5. Social Security Number 214-20-1005 Usual Residence of Decedent	x □M 2∰F 7. Ag	e (In yrs. 76	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da June 2	y Year) 6, 1928	9. Birthi Cour Mar	place (State or Fore ntry) yland	sign
	h the Maryland r 28a-f show	irector	10a. State 10b. County Maryland Anne Aru 10e. Street and Number			ty, Town or Lo		Code				10g. Citizen of V		10d. Inside City Lim 1 ☐ Yes 2 🖎	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examine trius be righted at once.	by Funeral Director	1091 River Bay Roa 11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 24 If Yes, Give Year or Dates:					spanic Origin, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	United 14. Race Blace Specify	e - Americ k, White,	can Indian,	
Maryland 21215-0036	od within 72 hou giene. er then "nature", the Medical E.	Completed I	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation	5+)		dent's Usua kind of wo DO NOT u	rk done d se retired)	ide			16b. Kind of Bu	ion	idustry	
yland	should be filed ind Mental Hygir s marked other umatic event, II	To Be (17. Father's Name (First, Middle, Last) Thomas Bennett	0/m		105 14-18			Mary	Sy1v	via Neat			Conto	
	Pages 1 and 2 st nent of Health and int: If Item 27 is n iry or other traun		19a. Informant's Name/Relationship (T) Caroline Musterma 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ F	n/ daught	20b. F		lue R	idge	Driv	e Ar	napolis Date	s, City or Town, MD 21 20c. Location Annapo1	401 City or To	own, State	
Baltimore,	permit. Po Departme Important eny injury		21. Signature of Funeral Service Licens		in	22	. Name ar	d Addres	s of Facilit	y Joh	in M. Ta	aylor Fu	nera	1 Home, 1 MD 21401	
1760,	Physician // Medical Examiner pe practical and pre prical-itansil	ical Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	a. Due to for a s	consecutive a consecutive	Quence of):	er the mod	n	S Ces		or respiratory ar	rest,		Approximate Interval Between Onset and Death 3 AAY 5	Zus
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate to within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	by Physician/Med	IF FEMALE: 23b. Was decedent premant in the past 12 months? 1 □ Yes 2 10 No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	ıl death 3 ☐	Ectopic pi					23d. Date Mor	e of delive	ery Day Year	
rds, P.	w requires that been signed by should be deta		Part II. Other significant conditions co	ntnbuting to death b	ut not res	sulting in the u	nderlying o	ause give	n in Part I.		23e. Did to		-	he cause of death? bably 4 □Unknow	
al Records,	sician: The law re certificate has be irector, page 2 sho	Completed									1 Yes	rmed?	Vere auto rior to co eath?	opsy findings availal impletion of cause of	ble of
Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 10 27. Manner of Death 1 Matural 5 Pending investigation	Hospital: 1 1 Impatie 28a. Date of Inju (Month, Da		ER/Outpatien 28b. Time of Injury	-	8c. Injury Work	r: 4 □ Nu at	rsing Ho		dence 6 □Othe		(ע'	
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			30. Name and address of person who co	ompleted cause of c	eath (Iter)ctens	L	uy	An	ng	lis, n	7/ 2	2140	o i	
	Sta Registi		MAR 2.3 201	75 Agree	ar a signa	k L	ack)	•		· J	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 21 per fb 842 4-11-05 vt.
State of Maryland / Department of Health and Mental Hygiene 1 1 5

For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 9:45 am Jacqueline Katherine Reedy March 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Yrs 438-26-9825 78 **Director** July 15 Louisiana Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28e-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19518 Spring Valley Drive 21742 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 ▼Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental 1 Andrew Francis Kelly Minnie Talley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 is n Dorothy Shipe/Daughter 11 North Colonial Drive, Hagerstown, Md. 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 3/28/2005 Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee any ir Eric L. Brown per dvr 1601 Pennsylvania Avenue, Hagerstown, Md. 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury nce of) Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No 9 Unknown signed by Part II. Other signif 23e. Did tobacco use contribute to the cause of death? contributing to death out not resulting in the underlying cause given in Part I. by eq 2 410 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate 2□ No 1 Yes 2 1 NO 1 Yes To the Hospital or Attending Physician: 25. Was case referred examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Impatient 2 ER/Outpatient 3□ DOA After this uneral 28d. Describe how injury occurred 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 29b. Signature and title of certifier 29c. License number 3665 who completed cause of death (Item \$3a) (Type, Print). STREET MN 11677m Day, Year) 32. Registrar's Signature State Registrar

			1 - State of Maryland / Department of Health a Certificate of Death		giene	12260
	Dhusia		Decedent's Name (First, Middle, Last)	2. Date of De Month	eath Day Year	3. Time of Death
	Physic /Medi		Woodrow Francis ROBERTSON	March	26 2005	4:50 AM
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	of Death	4c. County of Death	
			Washington County Hospital Hagerstown		Washino	itin
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8. Date of Bir Min. (Month, Da	rth ay, Year) 9. Birthp Coun	ace (State or Foreign try)
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	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		11	Od. Inside City Limits
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an	2 sho and I is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number			Code)
	12 mg	1 3	Sandra L. Culler - Daughter 7024 Sharpsburg P	ike. Keedy	sville. Md. 3	1756
ore			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	Date	20c. Location - City or To-	vn, State
Baltimore,	Pag ent nt: f		1 1 TO 1 TO 1 TO 1 TO 1 TO 1 TO 1 TO 1	3/29/05	Williamsport,	Maryland
alt	permit. I Departm Importer any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility		Funeral Home	- Alyton
Δ	Dep	ti. i	Host Livertal 415 E. Wilson B			21740
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	he H in 24 he Fi plete	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	h occurred at the time,	date and place, and due to	the cause(s)
0	To t	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, D	ay, Year)
			D 623:	27	3/29/06	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
SH	3+1		368 MILL ST. MACERTOWN	1 2174	O On Ban	roal
	Sta		31. Date filed (Month, Day, Year) 32. Begistrar's Signature		·	
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra ance.		1 ABurial 2 ☐ Cremation		val from St	ato	Place of Dispo cemetery, cren			- 1				cation - City		State
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State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Noah Martica Skinner Jr. 8:15a M 2005 March 26, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 201 South Church Street Sudlersville Queen Anne's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months M 2 F Days Hours 81 1924 Director 218-16-8061 ΜD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits rel', or Items 23e or 28e-f show Examiner must be notified at Sudlersville MD Queen Anne's 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21668 USA 201 South Church Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importment: If them 27 is marked other then "neturel", or iten eny injury or other treumatic event, the Mydral Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) construction 11 Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Noah Martica Skinner Sr. Anna May Moore ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian H. Skinner/wife 201 S. Church Street Sudlersville, MD 21668 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Sudlersville Mar 30 2005 Sudlersville 21. Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home 370 W Cypress St Millington, MD 23a. Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death toly cordie **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical the use as signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? 2 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerel C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) D0060301 ause of death (Item 23a) (Type, Print)
-X M LASSIEU RD STES CHESTENTOWN, 30. Name a EMER M 32. Registar's Signature 31. Date filed (Month, Day, Year) State MAR 29 2005 Registrar

			1- State of Ma		artment of Healt <i>rtificate of Dea</i>		ental Hygie . _{Reg.}	/1115	12263
			Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		William R. Spradbrow				March 2]	, 2005	10:00 p ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) Lorien Nursing Home		4b. City, Town, or Local Taneytor			4c. County of Dea Carr	
-	Funeral			(In yrs. last birthday)	If Under 1 Year If Ur	nder 24 Hrs.	8. Date of Birth		thplace (State or Foreign
	Director		220-22-6907 ^{1⊠M 2□F}	77 Yrs.	Months Days Hou	urs Min.	(Month, Day, Ye Nov 12,	1927	anada
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryli f sho	lor	Maryland Carroll	,,	West	tminste	r		1 ☐ Yes 2 ☑ No
	r 28e	irec	10e. Street and Number		10f. Zip Code	_	10g.	Citizen of What C	ountry?
	ath wit	Funeral Director	1517 Bachman Valley Road			1158		USA	
	er de litems	nne	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hispanio If Yes, specify Cuban, Me:	ic Origin? (Spec xican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Am Black, Whi	
20	urs aft	by	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	WII	1 ☐ Yes 2√2 No Spe	ecify:		Specify:	white
ה ה	n 72 hours after death with the Maryland "neturel", or Items 23e or 28e-f show coital Examirer must be notilited at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during	most of working	g 16b	. Kind of Business	/Industry
7	C 2 (8)	mpi	Elementary/Secondary (0-12) College (1-4or 5-	+) life. l	DO NOT use retired) Police Offic			Law Enfo	orcement
2	should be filed within nd Mental Hygiene. 'marked other then " umatic event, tre Mo	ပိ	12 17. Father's Name (First, Middle, Last)				(First, Middle, Maid	ien Sumame)	
Ū	lic ev	To Be	Norman H.G. Spradbrow			Mabel	Cuthberts	son	
<u> </u>	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, ILE M.		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and No				
.°	is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 Is marked other then other treumatic event, Ite M.		Dorothy Spradbrow, wife		Bachman Va	lley Ro		ninster, . Location - City or	
	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		osition (Name of matory or other place) Cremations	03/24		Hampste	
	permit. Pages Department of Importent: If it eny injury or o		21. Signature of Funeral Service Licensee MOO	1	2. Name and Address of F	-	Eline Fu		
<u> </u>	88 2 2 8		Stewer Wed		934 South Ma	ain St,	Hampstea		0/4
			23a. Part1. Ent in the disease, or complications that caused shock, or heart failure. List only one cause on each lin-	Θ.					Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	evebro (a consequence of):	sasanov	ACC (aent		(month
	Examiner			Consequence or,					
-	ק ק	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):					
	ecute and I-trans	Examiner	that initiated events c.	a consequence of):					
20100	fficate be executed g physician and as the burial-transit	aiE		, ,					
00	- CD cd	ledicai l							
ל מ	leath certifi attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 □ Live birth 2	2 ☐ Fetal death 3 ☐	Ectopic pregnancy			23d. Date of de Month	livery Day Year
5	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use a	hysician/M	1	ime of death 5	Other (specify)				
Ļ	that the part of t	by Ph	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause given in F	Part I.	23e. Did tobacc	o use contribute to	the cause of death?
5	w requires been sign should be						1 🗌 Yes	2 No 3 P	robably 4 Hiknown
ט ט	e law re has bei ge 2 sho	Completed					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
		Соп					performed		2 3 H 6
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Physicien: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	nt 2 ☐ ER/Outpatien	04		(Check only one)_ e 5 ☐ Residence	6 FlOther (See	mife)
5	g Phy er this	-	27. Manner of Death 28a. Date of Injury	y 28b. Time of			3d. Describe how in		cny)
5	Attending Physicien: The laver death. ector: After this certificate has by the funeral director, page 2	atio	2 Accident investigation	Year) Injury	M 1 Yes	2 🗆 No			
Š	0 # E C	ertification;	3 Suicide 6 Could not be determined 28e. Place of Inju	ry - At home, farm, str . (Specify)	reet, factory, office	28	Bf. Location (Street City or Town, St	and Number or R ate)	ural Route Number,
_	spitel	O	29a. Certifier 1 Certifying Physicien: To the best o	of my knowledge, death	h occurred at the time, dat	te and place, ar	nd due to the cause	e(s) and manner as	s stated.
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edicai	(Check only 2 Medical Examiner: On the basis of one) and manner state						
	To T	Σ	29b. Signature and title of certifier Wells MO		29c. License numl			Date signed (Mont	22 2005
	WILA		30. Name and address of person who completed cause of de	eath (Item 23a) (Tyne				urch	
	541		BINU CHACKO, 291 Stones	. 1	L West,	ministe	n MD	2/157	
	Sta			r's Signature					
	Registr	ar	MAR 2 8 2005	va St	Sozet				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Roy Buchman Singer, Sr. 2:00 a M March 26, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll 4420 Black Rock Road Hampstead If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Oct 14, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**√**2 M 2 □ F Yrs. Maryland Director 219-01-7840 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I're Medical Exame as moultied at 1 ☐ Yes 2 No Hampstead Maryland Carroll Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 4420 Black Rock Road #7 21074 USA death v permit. Pages 1 and 2 should be illed within 72 hours after dea. Department of Health and Mental Hygiene. Important: if tism 27 is marked other the any injury or other traum. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 ☑ No Specify: φ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NDT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Crane Operator 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Teressa Rose Mossmiller John William Singer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1458 Allen Way, Westminster, MD 21157 Roy B. Singer, Jr, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 03/29/2005 Hampstead, MD Carroll Cremations ` 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home /MØ0723 934 South Main St, Hampstead, MD 21074 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LUEEKS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 □ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ INSUFFICIENCY 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy 2 No 2 □ No 1 Yes Hospital or Attending Physician: 24 hours after death. Funaral Diractor: Atter this certifice Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the within 2 To the I 29d. Date signed (Menth, Day, Year) 29b. Signature and title of certifier 29c. License number 2005 WTIVP JEW. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UCURIS/HANKAR MORNING 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 28 2005 It sports Registrar

			State of Maryland / State of Maryland /	Department of Health and M Certificate of Death	lental Hygi	•	12265
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) Ethel L. Shroades 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month March	Day Year 22 2005 4c. County of Death	3. Time of Death 3:55 a ^M
	Examir Funeral	ier	2618 Birdview Road 5. Social Security Number 6. Sex 7. Age (In yrs. last b)	Westminster	8. Date of Birth (Month, Day,	Carrol 9. Birthe	place (State or Foreign
	Director wove		233-02-4243	vn or Location	October	11 1940	W • VA
	h the Mary or 28a-f sh a position	Funeral Director	MD Carroll V 10e. Street and Number	Vestminster 10f. Zip Code	10	g. Citizen of What Cour	1 ☐ Yes 2 ☒ No
	s 23a c	rai D	2618 Birdview Road	21157	acifu Vac ar No	USA 14. Race - Americ	can Indian
920	within 72 hours after death with the Maryland ane. than "natural", or liems 23a or 28a-f show ta Madical Existinet families and the modified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Mo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	эслу Yes or No- Rican, etc.)	Black, White,	
21215-0036	within 72 ho one. ihan "natur a Mazical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Homemaker	ing 1	6b. Kind of Business/In Own. Home	dustry
	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, II.≖ M.	To Be Co	17. Father's Name (First, Middle, Last) Charles Colbert	18. Mother's Name			
Baltimore, Maryland	Pages 1 and nent of Health ant: If item 27 ury or other tr		Stanley Shroades/husband 20a. Method of Disposition 20b. Place compete		stuinste Date 2	oc. Location - City or To	57
■ Balt	permit. Departr Importa		21. Signature of Funeral Service Licensee Multiple Complex Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	22. Name and Address of Facility. Pritts Funeral Home 412 Washington Road not enter the mode of dying, such as cardiac	Westmi	nster. MD	21157 Approximate Interval Between
3760,	/Medical Examiner /Medical Examiner /Medical Figure 1. Transit // A control of the principle of the princ	icai Examiner	Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o of):			[[MONTHS
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<u>α</u>	equires that en signed b ould be deta	ed by Pł	Part II. Other significant conditions contributing to death but not resulting ASHD	in the underlying cause given in Part I.	23e. Did toba	acco use contribute to to	
Il Records,	The law recate has be page 2 sho	Complet			24a. Was an autopsy perform 1 Yes 2	prior to co	ppsy findings available impletion of cause of 2 No
on of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2	26. Place of Death utpatient 3 DOA Other: 4 Nursing Ho Time of Injury Work? M 1 Yes 2 No	ýy)		
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	farm, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	he Hospital or n 24 hours afte he Funeral Dir bletely filled in t	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledged and manner stated.	ge, death occurred at the time, date and place, nd/or investigation, in my opinion, death occur	and due to the car red at the time, da	use(s) and manner as s te and place, and due to	tated. o the cause(s)
	WIL	×	29b. Signature and file of certifier M.D.	29c. License number 10059552		d. Date signed (Month,	
	10			(Type, Print) 700 A POOLE RD WESTIM	in STER 1	ma 21157	
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 4 2005	4. Sante			

		1 - For State Registrar	State of	i Marylai	-	irtment of t tificate of		Mental Hy	giene. U Reg. No.	UJ	12266
5		1. Decedent's Name (First, Middle, Las	(t)					2. Date of Dea	ath Day	Year	3. Time of Death
Physici		William Lee Satch	nell					March		2005	1600 M
/Medio Examin		4a. Facility Name (If not institution, give		nber)		4b. City, Town, o	or Location of Dea	ith	4c. County	of Death	
		Atlantic General 1	Hospita	1		Berlin			Word	ester	-
Funeral		5. Social Security Number 6. Se	Эх	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir				lace (State or Foreign stry)
Director		221–26–8340	ØM 2□F	62	Yrs.	Working Days	110013	Feb 13,	1943		7Á
p ,		Usual Residence of Decedent		100 0	ity, Town or Lo						0d. Inside City Limits
aryla show	_	10a. State 10b. County								1.	1 X Yes 2 □ No
ith the Marylan or 28a-f show	ctc	DE Sussex		FT	cankford				10. 02		
or 2	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of		ntry /
72 hours after death w "natural", or items 23s	rai	305A PepperRidge I			10 101	19945				S.	an Indian
ar de	une	11. Marital Status	12. Was Dece Armed Fo	rces?	J.S. 13. V	Yas Decedent of I Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	Bla	ck, White,	
s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes If Yes, Giv Year or Da	e zyzjino	1	☐ Yes 2 🔀 No	Specify:		Specif	y: B]	ack
hour		15. Decedent's Ed			16a, Deced	lent's Usual Occur	pation		16b. Kind of B	usiness/Inc	dustry
in 72 na nadis	ojet	(Specify only highest gra	de completed)		(Give	kind of work done OO NOT use retire	during most of w	orking			•
with ene.	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		Labore	r		va	rious	5
be filed within 72 hours after death with the Maryland half yejene. Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exatt mer must be invitted at	Be C	17. Father's Name (First, Middle, Last)			ţ		18. Mother's Na	ame (First, Middle,	Maiden Sumar	ne)	
ould be filed with Mental Hygiene arked other tha	To B	unknown					Ailena	Satchell			
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Men	-	19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailin	g Address (Street	and Number or F	Rural Route Numbe	r, City or Town,	State, Zip	Code)
P 5 5 5		Sally F. Satchell,	wife		27 Sh	nady Grov	ve, Selb	yville, D	E 19975)	
permit Pages 1 an Department of Heal Important: if itam 2 any injury or othar		20a. Method of Disposition		- 1	Place of Dispos	sition (Name of natory or other pla	ce)	Date	20c. Location	· City or To	wn, State
Pages nent of P ant: if its		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		40	oar Gold	den Acres Cemeter	5 12/2	0/2005	Selbyv	പ് 11ല	DE
mit pparit poorle y inju		21. Signature of Funeral Service Licen	S 00		22	Name and Addre	ess of Facility		A17-11-12/2015	,	
Depariment of the permit of th		MA			16	S18 West	Rd. Sa	uneral Ho lisbury,	me MD 2180	1	
		23a. Page. Enter the disease, or companies shock, or heart failure. List only	olications that cone cause on e	aused the dea	th. Do not ente	er the mode of dyi	ng, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between
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artiflic ing p		IF FEMALE:							T.		
leath certiff attending I for use as	ician/M	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Fet	al death 3 🗌	Ectopic pregnanc	у		I	ite of delive onth	nry Day Year
the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9☐ Unkno	ant at time of own	death 5	Other (specify) _					
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: Th cate pag	Ö							1 ☐ Yes	2 No	1 🗆 Yəs	2 No
sician: The law scertilicate has t lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			_ Ott	200	eath (Check only o			
Phys this al dia	1.	1 Series 2 No 27. Manner of Death	28a. Date o		ZER/Outpatien 28b. Time of	t 3 DOA 28c. Inju	4 Nursing	Home 5 ☐ Resid			/)
ding Physician: The h. After this certificate h tuneral director, page	tion	1 Satural 5 ☐ Pending	(Mont	h, Day Year)	Injury	Wo	rk?]Yes 2 ☐No		7		
er death	ica	3 Suicide 6 Could not be		of Injury - At I	nome, farm, stre	et, factory, office		28f. Location (S	Street and Numb	er or Rura	I Route Number,
i or after	ertification;	4 ☐ Homicide determined		ng, etc. (Spec				City or Tow	m, State)		
spita ours serei	O	29a. Certifier 1☐ Certifying Ph	ysician: To the	best of my kn	owledge, death	occurred at the ti	me, date and plac	ce, and due to the	cause(s) and ma	anner as st	ated.
To the Hospital or Attending Physician: The law requires that the death cartifuling to the hospital or Attending Physician: The law requires that the death cartificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical	(Check only 2 Medical Examone)		sis of examin							
Fo the formal fo	Me	29b. Signature and title of certifier			-	29c. Licen:			29d. Date signe		
, , , ,		South 0	Argun	#	The S.	1	06241		03-0	29-0	35
\		30. Name and address of person who	convileted caus	e of death (Ite	m 23a) (Type,	Print)	_		11		D. 21863
Uh		DOROTHY !	HOLZIN	ORTH	, M.D.	20	5 INDW	1 JT SX	10My HI	14,1	D. 21863

State Registrar

31. Date filed (Month, Day, Year) MAR 2 9 2005

DOROTHY HOLZ WORTH, M. D.

Date filed (Month, Day, Year)

MAR 2 9 2005

MAR 2 9 2005

ORIGINAL

			State 1- State Amend Item 23a pt	of Marylan .II,25,27				Mental Hygi 2-05 tas	-	12267
			Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
	Physici	an	NELSON SKOOL	A20				Month	Day Year	0735 AM
	/Medic		4a. Facility Name (If not institution, give street and			4h City Town	or Location of Dea	MAR	4c. County of Deat	
	Examin	er							Wic	
10-		-	5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	S A Col		S. 8. Date of Birth		hplace (State or Foreign
н	Funeral		10/14 20	F	Yrs.	Months Days	Hours Min	. (Month, Day,	Year) Co	untry)
	Director		577-46-1609 Usual Residence of Decedent	67			1	May 26,	1937 1	ınknown
	land		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Aary e sh	ō	MD Wicomico			Sa]	isbury			1 XYes 2 □ No
\forall	1588-	ec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
3	with or	ă	100 East Carroll St.			, o., z.p oodo	21801	1		, .
2	death with the Maryland ms 23a or 28a-f show Lives by nutified at	Funeral Director			C 12	Man Danadant of I		Specific Vac or Na	USA 14. Race - Ame	rican Indian
0	er de	nu	Arme	Decedent Ever in U. d Forces?	.5. 13.	If Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Black, White	
36	s aft	by F	If Yes	es 212 No , Give or Dates:		1☐ Yes 2⊠No	Specify:		Specify: W	hite
21215-0036	hour	D D		or Dates.	162 Door	dent's Usual Occur	ation		6b. Kind of Business/	Industry
फ़	"na din	Completed	15. Decedent's Education (Specify only highest grade completed)	red)	(Give	kind of work done DO NOT use retire	during most of wo	orking	OD. KING OF DUSINGSS	industry
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7	be filed within 72 hours after ital Hygiene. d other than "natural", or fte event, itte Medical Excholitie		10 17. Father's Name (First, Middle, Last)		<u> </u>	ULIKLIOWI		me (First, Middle, M	unknown	
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Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print)						City or Town, State, 2	(ip Code)
	1 and 2 Health Iem 27		Maryaret Bradford	p.r.			le Dr., S		MD 21801	-
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Importants if item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, the Mudical Examiner relations to proce.		20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal fr		emetery, crer	sition (Name of natory or other pla	ce)	Date	Oc. Location - City or	Iown, State
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at	Departi Departi Import Import Eny inj		21. Signatur of Funeral Service Licensee						eral Home	P.A.
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760,	Physician and // // // // // // // // // // // // //	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Ulstage of Hymy that initiated events c.	on each line. A S C V to (or as a consequence of to (or as a consequence	uence of):	CERTIF	CATION APPROVE	DAY MEDICAL EXAMIN	ER	Interval Between Onset and Death
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5	s cer	0	examiner? 1 Nes -2 Hospital:	□ Inpatient 2□	ER/Outpatien		er: 4 Nursing I		ice 6 Other (Spec	rify)
ō	Phys or this oral di	-	27. Manner of Death 28a. D	ate of Injury	28b. Time of	unk 28c. Injur	y at	28d. Describe hov		,,
o	th. Afte	Ē	Gentatural SCI briding	Month, Day Year) 1st 9,200	Injury 3	*****	κ? Yes 2 7 ΩNo	Subject s	uffered he	ad trauma
Divis		Certification:	3 Suicide 6 A Could not be determined 28e. P	lace of Injury - At ho uilding, etc. (Specify ect(found)	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,		a and Mills
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	To t To t	Σ	29b. Signature and title of certifier			29c. Licens			d. Date signed (Month	
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			30. Name and address of person who completed of Babulal wan.		23a) (Type,	Print)	T. # 504	FB Salis	bury Mi	21804
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}	/Medic Examir		4a. Facility Name (If not institution, give		CIOR				Location of		Intiton	4c.	County of	Dealh	L	
			628 SONATA WAY 5. Social Security Number 6. S	ey 7 An	a (In vrs la	ast birthday)		LVEK r 1 Year	SPRI If Under		8. Date of Bi	irth	9		ace (State o	or Foreign
	Funeral Director		356-38-0602	□ M 2 🔀 F	5		Months		Hours	Min.	_(Month, D	av. Year)	945	Coun ILL	INOIS	
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	or 28e	Director	10e. Street and Number			20121		Code				10g. Cit	izen of Wh	at Coun	try?	
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36	iiit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland artiment of Health and Mental Hygiana. critants: if item 27 is marked other than "naturel", or Itama 23a or 23e-f show notions: if item 27 is marked other than "naturel", or Itama 23a or 23e-f show notined an injury or other traumatic event, the Medical Expirition must be notified at the continued of the continued	by Funeral	11. Marital Status 1 🛣 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:			Was Dece If Yes, spe		spanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)	0-	14. Race - Black, Specify:	White, 6	etc.	
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Maryland	nd 2 sho lith and I 27 is ma r traums	0 3	19a. Informant's Name/Relationship (NEIL A. SPECTOR -	• .							al Route Numb					
ore,	of Head		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☑	Removal from State	20b. PI	lace of Dispo emetery, crei	osition (Na matory or	me of other place	a)	[Date	20c. Lo	cation - C	ity or To	wn, State	
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Bai	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra	ĺ	21. Signature of Europeal Service Licer	1599							MEMOR					
	SUICE		23a. Part1. Enter the disease, or com	plications that caused	the death	n. Do not ent	ter the mod	ROCK V	JILLE g, such as	cardiac	E , ROCI	KVILI arrest,	.Е, М	0 20	Approximatinterval Bet	18
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	a. BOWEL OF		OTTON								3	Onset and MONTI	Death
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). Box 6	death certifi e attanding d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal	death 3	∃Ectopic p ∃ Other (s						23d. Date Month		,	Year
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Division	Atten ector: by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined				reet, factor	y, office			28f. Location City or To	(Street and own, State		or Aura	l Route Nun	nber,
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	1)		30. Name and address of person who													
			LINDA M. BURRELL 31. Date filed (Month, Day, Year)					VD #4	00, 1	WHEA'	TON, MAF	RYLAN	D 20	902		
	Sta Regist			32 Registr	, K	Jan 20	and the									

State of Maryland / Department of Health and Mental Hygiene U 5 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Marjorie B. R. Smead March 23, 12:15^a M 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖾 F Director 217-46-4422 58 Nov. 23, 1946 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3888 St. Clair Court or items 23a Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 1965-76 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify:White 1 Yes 2 No Specify: à 3 Nidowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygier Important: If them 27 is marked other the any injury or other traumatic event, the page. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Franklin Robertson Dorothy Bennit 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Stracener/Executor of Will 13410 Dowlais Drive, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 29, 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2005 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Licensee University Blvd, W, Silver Spring, MD 20901 23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Privsician Chronic Obstructive Pulmonary Disease 5 years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate that the sample Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine certificate be executed burial-translt Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical as the l IF FEMALE 981 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ٥ Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Bladder Cancer, Osteoporosis 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 1 K Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural s after death.

il Director: Aff
id in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral 6 Hospital 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Dav. Year) D26540 March 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20877 Schoenberger, Carl I. 16220 Frederick Road, Suite 213, Gaithersburg, M.D.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR

28

38. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mohammed Musa Sayyad 3/24/2005 8:56 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months 1 ★M 2 F Director 227-47-7749 1/1/1944 61 Israel Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County from marked other than "natural", or Items 23a or 28a-f show traumatic event, the Nedical Examinar must be collined at 10d. Inside City Limits Md. Prince Georges Riverdale 1 XYes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6821 Riverdale Rd. #D202 20737 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is markad other than "natural", or Itel Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 unemployed none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Musa Sayyad Ameinah Abuhawa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Musa Sayyad / son 3315 Wyndham Circle #1233 Alexandria, VA22302 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page
Department of
Important: If
any injury or
once. *4 □Donation 5 □ Other, (Specify) 3/29/05 Family Cemetery Jerusalem, Israel 21. Signatur of Funeral Serve Licens e 22. Name and Address of Facility Universal Mortuary 411 Kennedy St., N.W. Washington, D.C. 2001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHERY SCLENTIC Priysician HEATT DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death P.O. P 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown ate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? certificate 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 - Homicide hours after within 24 hours at To the Funeral D 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 48083 460 3/24/05 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Irving Westney 7600 Carroll Takoma Park, Md. 20912 Ave State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 9 /Medical Marc 27 4:12 AM 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OUNTG HOSUSTOWN, MARN If Under 1 Year Inf Under 24 Hrs Months | Days | Hours | Min HOSDISTOWN WOSHINGTON WOSLINTON 5. Social Security Number 6 Sax Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 200 F 46 Director 214-80-5857 Vrs March 1 1959 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 28a-f show 10d. Inside City Limits treumatic event, the Modical Evand at must be notified at Directo 1 ☐ Yes 2√ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 or Items 23a 11545 Selema Drive Apt. 3 Funeral 21742 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 → Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Be Completed by 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced neturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) 12 other Registar Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden and Mental H Elwood Reeder ೭ Audrey Barnhart Hamby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21742 Department of Health Importent: If item 27 Jennifer L. Snyder (Daughter) 11545 Selema Drive Apt. 3 Hagerstown Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō 4 ☐ Donation 5 ☐ Qther (Specify) Cedar Lawn Mem. Park Apr. 1 05 Hagerstown Maryland 21. Signature of Femeral Pervice Licenses 22. Name and Address of Facility any Ir Douglas A. Fiery Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death 15/018 Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-transit Exam resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ned by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 3√2 No 1 🗌 Yes 1 Yes Hospitel or Attending Physicien: the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Thomicide pellij 24 hours a 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

(ounty

who completed cause of death (Item 23a) (Type, Print)

WOSHINGEN

32/Registrar's Signature

M.D

31. Date filed (Martin Pay, Year)

State of Maryland / Department of Health and Mental Hygiene U U 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Angela Toinette Tolbert 26 2005 /Medical MARCH 13:10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND
If Under 1 Year | If Under 24 Hrs. ALLEGANY **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Days 1 ☐ M 2 🖾 F 59 Yrs. Director 214-48-3173 07/06/1945 Maryland Usual Residence of Decedent deeth with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumetic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10102 Country Club Road Iteme 23a 21502 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Heelith and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Item any injury or other traumetic event, the Medical Exercising SIGE. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify 3 ☑ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerical Social Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Gershman Washington Kathleen Clemmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadette Washington / sister 4342 Taney Avenue, #202, Alexandria, VA 22304 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 03/27/2005 Cumberland Crematory Cumberland, MD ⁴ 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RENAL FAILURE 3 WEEKS /Medical Due to (or as a consequence of) Examiner SMALL VESSEL RENAL DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine y physicien and is the burial-translt Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check onl one examiner's 2Z No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation ofter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hc To the Fun completely 1 2 Medical Examiner: On the Datis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number March 27,2005 D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIK_POONAI, 924 SETON DRIVE, CUMBERLAND, MD 31. Date filed (Month, Day, Year) 37/Registrar's Signature State

Registrar

MAR 28 2005

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State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician MARCH 24, DEBRA ANN TAUB 2005 1:30 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner SUBURBAN HOSPITAL MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdav) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 X F Yrs **Director** 61 JUNE 13, 1943 WASHINGTON, DC 220-40-6719 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County r 28a-f show 1 √ Yes 2 No MARYLAND MONTGOMERY POTOMAC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral', or itams 23a or 9001 COPENHAVER DRIVE 20854 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 □ Widowed 4 □ Divorced WHITE 'natural' r than "natural the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) CONSUMER INFO. OFFICER GOVERNMENT/F.D.A. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be markad JACOB POLLEKOFF BEATRICE 2 WINTNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i DR. ALBERT TAUB/HUSBAND 9001 COPENHAVER DR., POTOMAC, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of F Important: If ite any injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) GARDEN OF REMEMBRANCE 03/27/2005 CLARKSBURG, MARYLAND 21. Signature of Funeral Service Licensee 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician a SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PERFORATED SMALL BOWEL Sequentially list conditions, if any, leading to immediate cause. End of John Ing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transi Due to (or as a consequence of): 68760, attending physician certificate be Physician/Medical Box IF FEMALE esn esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ğ 1 Yes 2 No 3 Probably 4 Unknown OBESITY ed Complet 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MALNUTRITION page 2 autopsy performed? 1 ☐ Yes 2 ☐ No MESH ABDOMINAL WALL HERNIA REPAIR 1 Yes 2X No Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 💢 No o this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide Hospital or 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Chack only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ar B92786 MARCH 25, 2005 12 13 30. Name and address of person who completed cause of death (Item 23a) Type, Print) ERNEST D. HANOWELL, M.D., 8600 OLD GEORGETOWN ROAD, BETHESDA, MD 20814 3 Registrar's Signature 31. Date filed (Month, Day, Year) State 28 2005 MAR Registrar

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di	/Medic	al	4a. Facility Name (If not institution, gi		os!		4b City T	Tourn or	Location o		March 2		05 nty of Death	6:45 p. м	
	Examin	er	140 Sunflower D		91)				town	Dealli			ashing	rton	
	Funeral Director		5, Social Security Number 6.		Age (In yrs. Ia	st birthday) Yrs.	If Under 1		If Under 2 Hours	Min.	8. Date of Birtl (Month, Day lug. 3, 1	Year)	9. Birthp	place (State or Foreign	
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						1	10d. Inside City Limits	
	Maryl -f sho	tor	Maryland Wash:	ington		Н	agers	town						1 ☐ Yes 2 📉 No	
	th the	irec	10e. Street and Number				10f. Zip (Code				l0g. Citizen o	of What Cour	ntry?	
	ath wi	rai	140 Sunflower Dr					217				USA			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then *natural', or Items 23a or 28e-f show any injury or other treumetic event, the Midfield Examinar must be muffied at page.	by Funeral Director	11. Marital Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 X Yes 2 If Yes, Give Year or Date	es? □ No		Was Decede If Yes, speci 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto P	cify Yes or No- lican, etc.)	14. R B	lace - Americ Black, White, cify: Wh		
21215-0036	within 72 ho ene. then *natur	Completed	15. Decedent's 8 (Specify only highest g Elementary/Secondary (0-12) 12		or 5+)	(Give life. i	dent's Usual kind of work DO NOT use ter ca	k done d e retired)	uring most	of workin	g	16b. Kind of		dustry Office	
nd 2	al Hygi al Hygi I other vent, I	Be C	17. Father's Name (First, Middle, Las	et)					18. Mothe	r's Name	(First, Middle,	Maiden Sum	ame)		
ylaı	ould b Menta	To	Walter Allen Tr								Mae Tr	-			
Maryland	d 2 sh th and th and 7 is rr treurr		19a. Informant's Name/Relationship Linda Tritch - v	1 11 2							Route Numbe				
Linda Tritch – wife 140 Sunflower Dr., Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State															
E O	Page: nent o ent: If ury or		1 ☐ Burial 2 🖺 Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		ates	gersto				3-30	-05	Hager	stown,	, Maryland	
Baltimore,	permit. Departn Importe any inju		21. Signature of Foneral Service Lice	ensee	- /										
	₫ D = @ O		415 E. Wilson Blvd., Hagerstown, Md. 21740												
	Priysician /Medical		shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	y one cause on eac	LU,	, (, such as t	Sargiac of	respiratory an	esi,		Approximate Interval Between Onset and Death	
	Examiner				as a conseque	ence of):									
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a conseque	ence of):									
	ate be executed hysician and the burial-transit	Examine	Cause (Disease or injury) that initiated events resulting in death) Last	c Due to (or	as a conseque	ence of):							-		
8760,	s be e.	icai E		d											
9	tificate ng phy as the	fedic		0,											
P.O. Box	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ☐ Fetal of t at time of dea	death 3	Ectopic pre Other (spe						Date of delive Month	ery Day Year	
	es De	by	Part II. Other significant conditions	contributing to deat	h but not resul	ting in the u	nderlying ca	use give	n in Part I.		/	bacco use co		ne cause of death?	
ecords,	w requir	Completed									24a. Was a			psy findings available	
Re	The te ha	omp									autops	ned?	prior to con death? 1 Yes	mpletion of cause of	
ta	icien: certifica ector, p	BeC	25. Was case referred to medical						26. Place	of Death	1 □ Yes (Check only or	2 N o	1 195	2 140	
> t <	ding Physicien: th. : After this certifica funeral director,	ပ္	examiner? 1 Yes 2 No	Hospital: 1 Inp		R/Outpatien		Othe	r: 4 🗆 Nur		e 5 Resid			(v)	
OU C	Jing P	:lon:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	28 M	ic. Injury Work	at ? es 2 □ N		3d. Describe h	ow injury occ	urred		
Division of Vital R	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification:	2 Accident investigation 3 Suicide 6 Could not determine	be 28e. Place of	Injury - At hon , etc. (Specify)	ne, farm, str					3f. Location (S City or Tow		nber or Rura	I Route Number,	
Ω	Hospitel of the hours of Funerel D Funerel D tely filled in		29a, Certifier 1 Certifying P	hygician. To the be	at of my know	dedee dooth	a courted a	t the time		d place on	and advise to the ana				
	e Hospitel 24 hours a e Funerel I	edical	(Check only 2 Medical Exa	hysicien: To the be miner: On the basi and manner	s of examination	on and/or inv	vestigation, i	in my opi	inion, deat	h occurred	d at the time, d	ause(s) and r ate and place	manner as st e, and due to	the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier					License			2	9d. Date sign			
)			Muchael	1	ement			04	166	57		3 .	29.0	25	
St.	1-8+1		30. Name and address of person who	completed cause of	of death (Item :	23a) (Type, Ne.d	Print)	Com	W (c.)	12	renh	w	mp	21742	
	Sta		31. Date filed (Month, Day, Year)	32. Rég	istrar's Signatu	ire	81860		1		٠, .		, , , , , ,	21742	
	Registr	ar		14	www.	. Isli	Manager .								

			1 - For State Registrar	State of Maryla		artment of H			ene	
	Physic		1. Decedent's Name (First, Middle, Las Jay Lowell TROXEI	*				2. Date of Death Month	Day Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give 20035 Landis Road	<u> </u>		Hageı	or Location of Dea	th	4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. Security Number 217–28–6701 Usual Residence of Decedent	7. Age (In yı XI M 2 ☐ F 72	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Mir		9. Bi (1932 M	rthplace (State or Foreign Country) aryland
	e Maryland Ba-f show tiffed at	Director	10a. State 10b. County Maryland Washing		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
	th with the 23a or 2	al Dire	10e. Street and Number 20035 Landis Roa	d		10f. Zip Code 2174	12	10g	Citizen of What C	country?
9036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show aumatic event, Ir.e.Ms.d.cal Examiner must be routified at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ∑ Yes 2 □ No If Yes, Give Year or Dates: 195		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☒ No	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- nto Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	ithin 72 h ne. nan "natu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo d)	orking 16	b. Kind of Business	s/Industry
nd 21	e filed wall Hygien other th	Be Con	12 17. Father's Name (First, Middle, Last)	5	spee	ech patho		me (First, Middle, Ma	educa iden Sumame)	tion
ırylaı	should b nd Menta markad imatic e	To	Joseph L. Troxe11		19b. Mailin	na Address /Street		Margaret Tl	<u> </u>	Zin Code)
	1 and 2 Health ar am 27 is ther trau		Charles Clopper -			09 Whitne		Hagerstown	n, Md. 21	740
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 Is markad any injury or other traumatic soons.		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cren	natory or other place en Cemete	'		c. Location - City or Hagerstow	n, Maryland
Bal	Depar Impor any in		21. Signature of Euroral Service Licens	Mun		Name and Address	,	MINNICH FU , Hagersto		
	Physician /Medical Examiner	lner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ilications that caused the de ne cause on each line. a. Due to (or as a const.) Due to (or as a const.)	ARDI/ equence of):	er the mode of dyin	/ -	c or respiratory arrest.		Approximate Interval Between Onset and Death
8760,	cate be executed chysician and the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
P.O. Box 6	death certifi e attending p d for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	livery Day Year
	s tha	d by PI	Part II Other significant conditions con	ntributing to death but not re	esulting in the un	derlying cause give	en in Part I.			the cause of death?
Records,	law as b 2 sl	nplete	Herrens	37				24a. Was an autopsy	24b. Were au	utopsy findings available
Vital F	That are page	Be Cor	25. Was case referred to medical	m/A			26. Place of Dea	performed	no death? No 1 ☐ Yes	completion of cause of
of	g Physician: er this certific eral director,	၉	27. Manner of Death	dospital: 1 Inpatient 2[28a. Date of Injury (Month, Day Year)	ER/Outpatient	3 DOA Othe	er: 4 ☐ Nursing H		e 6 ⊡Other (Special	cify)
Division	ttanding f death. ctor: After y the funer	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Injury	M 1 🗆 `	Yes 2 □No			10
Div	oital or A urs after iral Dira illed in by		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	:ify)			28f. Location (Street City or Town, St	tate)	
	To the Hospital or Attanding Phwithin 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Medical	one)	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death nation and/or inve	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the cause rred at the time, date	(s) and manner as and place, and due	s stated, to the cause(s)
	To the within To the comple	2	29b. Signature and title of certifier	Bon		29c. License	599L	1 29d.	Date signed (Montl	h, Day, Year)
SH	1-10		30. Name and address of person who co	empleted cause of death (Ite	em 23a) (Type, P	Print)	Canal	WSRA H	1 control	MD 2174.2
	Sta Registr		31. Date filed (Month, Day, Year)	32. Přigištrar's Sign	nature	cell)	C) COM	311021 110	1 310-1	-11/10

ey	ally CO.		_ FOI	partment of Health and N ertificate of Death		ene 005	12277
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		REGINA ANN VASSALLO		MARCH 2	22, 2005	11:10 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
			235 PACA STREET, #510	CUMBERLAND		ALLEGA	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In yrs. last birthd:	Months Days Hours Min.	8. Date of Birth (Month, Day,) OCT • 30,	(ear) Co	thplace (State or Foreign ountry) RYLAND
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Leasting			10d. Inside City Limits
	lanyla ahov	5					1 X Yes 2 □ No
	the M	Director	MD ALLEGANY CUMBE	RLAND 10f. Zip Code	100	g. Citizen of What Co	puntry?
	with a or		235 PACA STREET, #510	21502		U.S.A.	1111
	death	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Sr	pecify Yes or No-	14. Race - Ame	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Itams 23a or 28a-f ahow maric event, Ite Wedsal Examiner mast to neillind a	by Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerion 1 ☐ Yes 2 ☐ X No Specify:	o Hican, etc.)	Specify: W	e, etc. HITE
5-0036	2 hou stura	ed	15. Decedent's Education 16a. De	cedent's Usual Occupation	16	5b. Kind of Business	
215	within 72 ene. than "nat	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of work a. DO NOT use retired)	king		
2	ad with	Som		OMEMAKER		HOME	
aryland 2121	ould be filed a Mental Hygis tarkad othar i	Be	17. Father's Name (First, Middle, Last) CURTIS R. PORTMESS	18. Mother's Nam	ne (First, Middle, Ma LOU KI	aiden Sumame) ESSLER	
ž	s 1 and 2 should f Health and Men itam 27 is marks other traumatic	To		ailing Address (Street and Number or Ru			Zip Code)
<u>8</u>	and 2 sho salth and n 27 is m			PACA STREET, CUME	BERLAND, 1	MD 21502	
ē,	s 1 and if Health itam 27 othar tr		cemetery	sposition (Name of rematory or other place)	Date 20	oc. Location - City or	Town, State
altimore,	Pages nent of l int: If its		Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) BETHEL		5/2005	PAW PAW	WV
Balti	permit. Pages 1 Department of H Important: If ital any injury or ott		21. Signature of Funeral Service Licensee	HOME, P.A.		21502	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Rome Lune 1) setre		Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):				7
	Examiner	_	Sequentially list conditions, b.				
	ed sit	Examiner	if any, leading to immediate Due to (or as a consequence or):				
	xecut and al-tran	хап	Cause (Disease or injury that initiated events c				
8760,	icate be executed physician and s the burial-transit	dicai E	L _a				
687	ificate g phy as the	00 1	<u> </u>				
Вох	eath certific attending p for use as	M/ui	JF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of de	*
	ne deat the att	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown in the past 12 months? 4 □ Pregnant at time of death 9 □ Unknown	5 Other (specify)		Month	Day Year
P. 0	that the de led by the detached	Phy	Part II. Other significant conditions contributing to death but not resulting in the	a underlying cause given in Part I.	23e. Did toba	cco use contribute t	the cause of death?
Vital Records,	es on on on	d by	Takin, Gillor Organical Control of the Control of t	, , , , , , , , , , , , , , , , , , , ,	1 Yes		robably 4 Unknown
000	sw requir	Completed			24a. Was an	24b. Were a	utopsy findings available
æ	sician: The law certificate has birector, page 2 s	omo			autopsy performe		completion of cause of 2 □ No
ta		Be C	25. Was case referred to medical	26. Place of Dea	th (Check only one)		
	hysician: this certific al director.	ToE	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa		ome 5 Residen	ce 6 □Other (Spe	icify)
0 _	Attending Physician: or death. actor: After this certific by the funeral director.		27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 ► Natural 5 □ Pending	y Work?	28d. Describe how	injury occurred	
S S	tendi leath. tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury - At home farm	M 1 Yes 2 No	28f Location (Stre	eet and Number or R	ural Poute Number
Division of	l or Attenuation death Diractor:	ertification;	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, ractory, office	City or Town,		orgi i rodio i romosi,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	saic	29a. Certifier 1 Certifying Physician: To the best of my knowledge, d				
	tha H hin 24 tha Fi	Medical	one) and manner stated.	29c. License number		d. Date signed (Mon	
		=	29b. Signature and title of certifier		_		-
,	4		20 Name and obtained to come the company of the ability of the	Print)	1 //	MICHA	1,2005
	nas		30. Name and address of person who completed cause of death (Item 23a) (Ty	DO 18 DO 18	emberzi	nd, MD .	21502
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Coules			
	Regist	ar	MAR Z 4 ZUUD	17			

State of Mar

ryland / Department of Health and Men	tal Hygiene	12278
Certificate of Death	Per No.	16610

										neg. No.				
		1. Decedent's Nam	a (First, Middla, L.	ast)					2. Data of Da		3. Tima of Daath			
	Physician	**		77.1	. 1 .1		T.7		Month Manager 1	Day Yas				
April	/Medical	Hern			izabeth		Wa	gner	March 1 or Location of Daat		3:30 AM			
-	Examiner	4a Facility Nama (it not institution, gi	ve straat and number)				4b. City, Town, o	or Location of Duct	4c. County of Di	eatii			
	e	Cumb	perland Vil	la Nursing Co	enter			Cumberla		Allega				
	Funeral	5. Social Sacurity N			a (In yrs. last		If Under 1 Yaar Months Days			th 9. I	Birthplaca (State or Foreign Country)			
	Director	217-10-69	951	1□M 27 F	8 9	Yrs.	viorano Dayo	1,00,0	08/15/1	.915 Ma	ryland			
6	73	Usual Rasidanca o												
	ylen/	10a. Stata	10b. County		10c. City, T	own or Loca	tion				10d. Insida City Limits			
	Man Fish	MD	A11e	egany		Cumber	rland				1 ☐ Yes 2 € No			
	vith the Ma t or 28a-f s be notified Director	10e. Street and Nu	<u> </u>	Garry		Junio C.	10f. Zip Code			10g. Citizan of What	Country?			
	€ 5 E			B (Church L	ono)		2150	12		USA				
	r items 23 directment Funeral	Nout	Le 3 DOX 70											
	e i e	11. Marital Status		12. Was Decadanf Armed Forcas?		13. Wa	is Decedant of I as, specify Cub	Hispanic Origin? (pan, Maxican, Pua	(Specify Yas or No arto Rican, etc.)	14. Hace - A Black, W	marican Indian, hita, atc.			
0	유 분들 때	1 🗌 Naver Marr	riad 2 Married	1 ☐ Yas 2 💢 I If Yes, Giva	No	10	Yas 20 No	Spacify:		Spacify:				
8	Every	3	4 Divorced	Yaar or Dates:			z res z zg	opu,		Spaciny.	White			
7	ed within 72 ho ygiene. er than "naturi it, me Medcal. Completed	(2	15. Decedant's E	ducation	1	6e. Deceder	nt's Usual Occu	pation	orkina.	16b. Kind of Busine	ss/Industry			
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Ξ	A Series	12		Collega (1-4or 5	77)	F	Homemaker			Homem	aker			
ס ס	Hyge H	17. Fathar's Name		t)				18. Mothar's N	ame (First, Middla	, Maiden Sumama)				
Ë	be fill H od out out				rman		Hast	Sarah	E	Elizabeth Goodwin				
ž	Ment Ment arke	Char												
Maryland 21215-0020	2 sh end is m	19a. informant's N	ame/Relationship	(Typa, Print)	1	19b. Mailing	Address (Strea	t and Numbar or i	Rural Route Numb	er, City or Town, State	e, Zip Coda)			
	alth 27	Dorothy Ro	oberson / n	iece	F	.O. Box	365, Cu	mberland,	Maryland	21 501 - 0365				
<u>e</u>	of He oth	20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatery, crematory or other place) 20c. Loc camatery, crematory or other place)									or Town, Stata			
2	age anto t: # y or										d, MD			
₹	rtan njur	21. Signature				22.8	Jama and Addr	ose of Eacility	Adams Fami	ly Funeral Ho	ome. P.A.			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar, or items 23s or 28s-f show any injury or other traumatic event, the Madical Examinar must be notified at once. To Be Completed by Funeral Director	21. Signature	an rai service Lice	1	- /	22.1				and, MD 2150				
	20240	to	but C	. (llas	und		404 DCCC	acur serce	e, cumbern					
		23a. Part1. Entar t	tha disaasa, or cor	nplications that causad	tha daath. [Oo not antar	tha mode of dy	ing, such as cardi	iac or respiratory a	rrast,	Approximata Intarval Batween			
*	Physician	SHOOK, OF HELD	in landio. List only								Onsat and Death			
d.	/Medical	Immadiata Causa		Cone	land 160	01.	0 . 1	tacida	nl-		5 Years			
1	Examiner	disaasa or condition rasulting in death)	on		o years									
	a				Dua to (or as	a conseque	ence of):				1			
	th certificate be executed lending physicien end in use as the buriel-trensit anyMedical Examiner			b										
	eeth certificate be executed ettending physicien end for use es the buriel-trensit cian/Medical Examin	Sequantially list co if eny, leading to in cause. Enter Unda Cause (Disaasa or that initiated avants	onditions,		Dua to (or as	a consaque	ence of):							
Ö,	uniel Line	cause. Enter Unda	arlying											
32	ate b nysic he b	that initiated avanta resulting in daath)	s Last	V	Dua to (or as	a conseque	nca of):							
Box 68760	as t	,												
ŏ	andir use			d										
m	d for	Part II. Other elanit	ficent conditions	contributing to death be	ut not resultin	a in the und	erlying causa gi	iven in Part I	23h Did	tohacco use contrib	uta to the cauaa of death?			
o.	y the oche	Turni. Other eigini	noam oonamone	oon the bearing to document		9	o,g oou g.				Probably 4 DUnknown			
Δ.	that ed b dete								_	108 2010 30	1 Tobabiy			
Division of Vital Records, P.O.	The law requires that the deeth certificate be executed cate has been signed by the ettending physicien end page 2 should be deteched for use as the bunsi-trensit Completed by Physician/Medical Examir								240 14/	an autopsy 24	b. Were autopsy findings			
5	equi									ormad?	available prior to completion of cause			
Ö	aw r										of death?			
Œ	te he sage								101	Yes 25 No	1 ☐ Yes 2 ☐ No			
<u>ra</u>	entifica ector, p	25. Was case refer	rred to medical	1				26. Place of D	eath (Check only o	one)				
>	sicis cert irect	examiner? 1 ☐ Yes 2☐		Hospital: 1 ☐ Inpatie	2 DEB	/Outpatient	3□ DOA Ot			danca 6 □Other (S	necify)			
ō	Phy ral c	27. Mannar of Deat		28a. Date of Inju		b. Tima of				how injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
5	Attending Physician: or death. ector: After this certific by the funeral director, lification: To Be (Natural 5 Panding (Month, Day Year) Injury Work?												
S	tend feath for: the	2 ☐ Accidant 3 ☐ Suicida	6 Could not	he	415				20f Location /	Street and Number of	Rural Route Number,			
≥	rectification by	4 ☐ Homicida	determine	28e. Place of Injusting, etc.	ury - At noma c. <i>(Specify)</i>	, tarm, stree	t, ractory, ornica		City or To	wn, State)	ridiai riodia ridinoai,			
	To the Hospital or Attending Physician: The law requires that the deeth within 24 hours effer death. To the Funeral Director: After this certificate hes been signed by the effect completely filled in by the funeral director, page 2 should be deteched for Medical Certification: To Be Completed by Physicia								1					
	he Hospi in 24 hou he Funer pletely fill edical	29a. Cartifiar (Check only	Certifying P	hysician: To the best of miner: On the basis of	of my knowled	dga, death o	ccurred at tha t	ime, date end pla-	ce, and dua to the	cause(s) and mannar	es stated. due to tha cause(s)			
	n 24 n 24 plete	one)	A CONTRACTOR OF THE PARTY OF TH	and manner sta	ated.			-pinon, adam ou						
_	M	29b. Signatura and	titla of certifier	•			29c. Lican	sa numbar		29d. Date signed (Me				
			HL	frame			Doo	33280		Morel	17,2005			
	,	20 Nome and add	jn	completed escreted of	leath /Ita- Co	a) /Tuna Pa					/			
	TILS	30. Neme end addr	V	completed cause of d										
	11 100	24 Date file of the		Gupta, M.D.			venue, Cı	mberland,	Mary land	21502				
	State	31. Data filad (Mon	4.0	005 32. Degistra	ar's Signatura									
	Registrar	TA .	MUK TO	HIP C.	· · · · · · · · · · · · · · · · · · ·	· Park	2 A. M. A.							

DHMH 16 Rev 6/95

			For State Registrar	State	of Marylar		artment of H			giene Reg. No.	005	12279		
ı	Dhomini		1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea	ith Day	Year	3. Time of Death		
	Physicia /Medic		Gladys		Fa	ay	White		March	30,	2005	10:15 P M		
	Examin	er	4a. Facility Name (If not institution	-	rumber)			Location of Deat	th	4c. (County of Death			
			12811 Bunting St 5. Social Security Number	6. Sex	7 Ann (In use	(and high-day)	Cumber If Under 1 Year	rland	Donn of Birth	1	Allega	J		
	Funeral Director		220-30-7826	1 M 2 X F	7. Age (In yrs. 70	Yrs.	Months Days	Hours Min.	(Month, Day			nplace (State or Foreign untry)		
			Usual Residence of Decedent		10				10/30/193	54	Mary	Land		
	how	_	10a. State 10b. County		10c. Ci	ty, Town or Lo						10d. Inside City Limits		
	e Ma 3a-fa	ctol	MD Alle	gany		Cumb	erland					1 ☐ Yes 2 ဩNo		
	or 28	Director	10e. Street and Number				10f. Zip Code	F00		10g. Citiz	en of What Cou	untry?		
	s 23a	ral		unting Stre		10 10		.502			USA			
	Item	Funeral	11. Marital Status 1 □ Never Married 2 □ Mar	Armed	cedent Ever in U Forces? 2 🛣 No	7.S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	Specify Yes of No- to Rican, etc.)	1	 Race - Amer Black, White 			
200	urs af	by F	3 X Widowed 4 Divorced	If Yes. (Bive		1 ☐ Yes 2 ☒ No	Specify:			Specity: Wh	ite		
5	2 hor			it's Education	4)	16a. Deced	lent's Usual Occup	ation		16b. Kin	nd of Business/I			
Ž	thin 7	nple	(Specify only higher Elementary/Secondary (0-12)	<u> </u>	(1-4or 5+)	life. l	kind of work done on NOT use retired	during most of wo.	inking					
V	ed wi ygien yer th t, the	Completed	10			N	urse's Aid		Hospital					
2	be fill htal H ad oth	Be	17. Father's Name (First, Middle, Ira	Last) Daniel		Dream			ame (First, Middle, Maiden Surname)					
5	d Mer narke	٦	19a, Informant's Name/Relations			Ryan		Maude	Golden Clites Rural Route Number, City or Town, State, Zip Code)					
2	d 2 sl th and th and 7 is r traur		Royce R. Ryan /			erland, Mar			ip Code)					
บ์	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or Items 23a or 28a-f ahow important: If tiem 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Modeal Examination and the modified at once.		20a. Method of Disposition	DIOCHEI		Date -	,	ation - City or 1	Town, State					
Dallillor	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Θ)	VVVV 48								
	mit. F portar injur		21. Signature of Funeral Service		, CC		Crematory Name and Addres		1/2005 Adams Famil	y Fur	berland. neral Home	Maryland e. F.A.		
Ď	Departing Departing Important any ir		* Kahit (- all	L		et, Cumberl	·						
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	g, such as cardia	c or respiratory arr	est,		Approximate Interval Between					
	Physician		Immediate Cause (Final disease or condition	10	1014774	TC i	IVER	CIRRHO	21/2			Onset and Death		
	/Medical Examiner		resulting in death)	-	o (or as a consec									
	LAGITITICI	_	Sequentially list conditions,	b	o for as a consac	wanna alli								
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	}	o por as a conse.	inerice of								
	execu n and ial-tra	Exal	that initiated events resulting in death) Last	c	o (or as a consec	quence of):								
, o	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d										
0	ng ph as th	Med	IF FEMALE:							-				
5	ith ce itendii or use	an/h	23b. Was decedent pregnant in the past 12 months?		utcome of pregna birth 2 Feta		Ectopic pregnancy			23	3d. Date of deliv			
	the at	Physiclan/Me	1 Yes 2 No	4□Pre	gnant at time of d nown	leath 5	Other (specify)				Month	Day Year		
	that the death certific ed by the attending p detached for use as		Part II. Other significant condition	ons contributing to	death but not res	sulting in the ur	nderlying cause give	en in Part I	23e. Did to	bacco us	se contribute to	the cause of death?		
Ď,	uires that signed b	d by		3		,	,,g g			es 2 🗹	_	bably 4 Unknown		
5	w requir	lete							24a. Was a	n	24h Were aut	opsy findings available		
ב	ician: The lav certificate has ector, page 2:	ompleted							autops	med?	prior to co death?	ompletion of cause of		
0	yalcian: The l is certificate ha director, page	e C	25. Was case referred to medica	ı				26. Place of Dea	1 ☐ Yes		1 🗆 Yes	2 L No		
>	Phyaici this cer al direc	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3□ DOA Othe	20	lome 5 Reside		Other (Speci	ify)		
) =	Itending Ph Jeath. Tor: After th the funeral													
200	tendi leath. tor: A the fu	catl	2 Accident investi	gation not be				M 1 ☐ Yes 2 ☐ No						
7 / 7	or At ifter of Direct in by	Certification:	4 Homicide determ	ined 28e. Plac	ce of Injury - At hi ding, etc. (Specil	ome, farm, stre fy)	m, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)					al Route Number,		
-	pital ours a interal i		29a. Certifier 1 X Certifyin	ng Physician: To the	ne heet of my kno	wladae death	occurred at the time	o data and place	and due to the e	21122/2) 2		etatod		
	To the Hospital or Attending Physician: whim 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examina nner stated.	ition and/or inv	estigation, in my of	pinion, death occu	urred at the time, d	ate and p	place, and due	to the cause(s)		
	To th To th comp	Me	29b. Signature and tille of certifie	110			29c. License	number	2	9d. Date	signed (Month,	Day, Year)		
	3) jacyy	MO				D50931		March	31, 2005	5		
	-10		30. Name and add as a person					-777						
	11 de		Virginia D.	32	Parietrar'e Signs	aturo	Drive, Cum	berland, M	lary Land 2	1502				
	Sta Registra	_	31. Date filed (Month, Day, Year) MAR 3	2005	Agistrar's Signa	H.	serde							
			mrn U.	- 6000	ALANDON A. M.	17								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Out

			1 - For State Registrar	State of Ma		ertificate of	tealth and Mei <i>Death</i>	ntal Hygie Reg.	-000	12280			
	Dhysia	ion	1. Decedent's Name (First, Middle, Last)				Date of Death		3. Time of Death			
	Physic /Medi		William N	Wisne	05			Month 3	Day / Year 23/05	(10A M			
1	Exami	ner	4a. Fecility Name (If not institution, give	street and number)			Location of Death		4c. County of Deat				
			Copper Ridge 5. Social Security Number 6. Se	17.	7.		sville		Carr				
	Funeral Director		212-22-8942	X 7. Age	82 Yrs.	Months Days	If Under 24 Hrs. 8. Hours Min. So	Date of Birth (Month, Day, Ye ep 21, 1		nplace (State or Foreign untry) Cyland			
	land		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits			
	Mary Ffah	to	Maryland Baltim	ore			Upperco			1 ☐ Yes 2√2 No			
	th the	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?			
	23a		3738 Black Rock	Road			21155		USA				
	er deg	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Specify n, Mexican, Puerto Ric	Yes or No-	14. Race - Amer Black, White	ican Indian,			
21215-0036	72 hours after death with the Maryland natural; or Items 23e or 28e-f ahow Alea Examinat must be multied at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	O AAAATT	1 ☐ Yes 2 ☑ No	Specify:	,		white			
5-	- 10	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dec	edent's Usual Occupa	ation furing most of working	16b	. Kind of Business/I	ndustry			
121	-= -	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	+) ///e.	DO NOT use retired)		State o	•			
92	0 0 0	e Co	17. Father's Name (First, Middle, Last)	4	Cert	iriea Pub	lic Account 18. Mother's Name (Fi		Maryl	and			
Maryland		To B	Charles Wisner				Blanche						
ary	2 shou and M la mar	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mai	ing Address (Street a		Rural Route Number, City or Town, State, Zip Code)					
			Jeanne Rambow, d	aughter			Schoolhouse						
ore	iges 1 ar of Hea or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	emoval from State	20b. Place of Disp	osition (Name of matory or other place	Date	-	Location - City or T				
Baltimore,	t. Pa rtmer rtant		' 4 ☐ Donation 5 ☐ Other (Specify)	03/26/2	2005	Upperco,	MD						
Bal	Depa Impo		21. Signature of Fuheral Service License	UMA	723	2. Name and Addres	^{s of Facility} Eli n Main St,		ral Home	074			
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused in ecause on each line	he death. Do not er	ter the mode of dying	g, such as cardiac or re	spiratory arrest.	ady PID ZI	Approximate			
	Physician		Immediate Cause (Final disease or condition	(pron	ara - d	ton Die	0000		14	Interval Between Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or as a	cons quence of):	07 121				Leovs			
	ZAGIIIIICI	-	Sequentially list conditions.	(erel	DANASES	la A	ccidery			Weeks			
170-	uted Insit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 10 (31 a3 a	consequence or,								
Ć,	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):								
68760,	rificate be executed ng physician and as the burial-transit	edicai		l									
	artifica ing pt e as t		IF FEMALE:										
Box	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o 1 ☐ Live birth 2	Fetal death 3[Ectopic pregnancy			23d. Date of deliv Month				
P. O.	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/M	1 □ Yes 2 □ No 9 □ U⊓known	4□Pregnant at ti 9□Unknown	me of death 5[Other (specify)			WIGHT	Day Year			
	es tha gned be del	by P	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobacco	o use contribute to t	he cause of death?			
ord	equir sen si		Attrict fibri	Matin	Kyper	Upiden	-	1 Tes	2 →No 3 □ Prot	oably 4 Unknown			
Records,	taw r	Completed	Hypertensa		Dene			24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of			
		Con	' /					performed? 1 ☐ Yes 2 ☐	death?				
Viita	Physician: this certificatal director, I	Be	25. Was case referred to medical examiner?	ospital:		Otho	26. Place of Death (Ch						
	Physical Carlo	. To	1 Yes 2 No	1 Inpatient 28a. Date of Injury	2 ER/Outpaties 28b. Time o		4 or sursing Home	5 Residence Describe how inj		y)			
on	Attending Phy ir death. ector: After thii by the funeral c	atior	Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Work*	? es 2 □ No	Describe now in	dry occurred				
Division of	r Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury	y - At home, farm, str	reet, factory, office	28f. L	ocation (Street a	and Number or Rura	I Route Number,			
ā	oital or urs afte oral Dia						N.	City or Town, Sta					
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 2 Medicel Exemin	icien: To the best of er: On the basis of e and manner state	xamination and/or in	n occurred at the time vestigation, in my opi	e, date and place, and on nion, death occurred at	due to the cause(the time, date a	s) and manner as sind place, and due to	tated. the cause(s)			
	To T To 1	Σ	29b. Signature and title of certifier	. /		29c. License	cense number 29d. Date signed (Month, Dey, Year)						
	WILLA		· welly	L-11	10	Poo	58137	3	123/05				
	10-41		30. Name and address of person who con	70- 1	11.	Print)	Westn	2.64	110 2				
	Sta	е	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	11 70	e>7~	·nster	NI) LII	> /			
L	Registra	ır	MAR 2 8 2	005	w ll	hand .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 27, . 2005 Physician 3:55 a [™] Elizabeth Doris Hagopian Whelan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9011 Black Dog Alley Talbot Easton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fo. Country)
April 8, 1928Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 171-22-9314 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28e-f show treumatic event, the Medical Exercit or must be rightled at 1 ☐ Yes 2 ☑ No Director Talbot Maryland Easton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 9011 Black Dog Alley 21601 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dietician Health 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be fund Mental ? Harry Der Hagopian Veta Gatonia Merleno 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s nent of Health an ant: if item 27 is r 9011 Black Dog Alley, Easton, MD 21601 Elise Eunice Hughes/Daughter other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ö MidShoreCremationCenter 3/29/2005 Cambridge, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) injury 21. Signature of Figheral Service Licensee Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 23a. Lett I here the disease, or come mations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition BRMN ORGANIC Y RMS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner ed by the attending physician and detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ FRACTURES 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed OSTROPOROSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ပို 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 124 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier within 2 To the I 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier Cuw fram 00000 250 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANG FIRSTON, TD. 609 DUTCITH MNS 9 2005 Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Da

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - State Registrar	Department of Health and Men Certificate of Death	tal Hygien	211115	2282			
	Physic		1. Decedent's Name (First, Middle, Last) Arthur Stokes Wheatley	N	Date of Death Month Date Ch 21	ay Year	Time of Death			
	/Medi Examii		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	<u>:10 ມ.™</u>			
	Funeral		1319 Hudson Road 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	Cambridge rthday) If Under 1 Year If Under 24 Hrs. 8, p.	late of Righ	Dorchester				
	Director		157M 2015	Months Days Hours Min. (A	nate of Birth Month, Day, Year DV • 12,	1919 Mary	State or Foreign			
)	death with the Maryland ms 23e or 28a-f show	tor	MD Dorchester 10c. City, Town	m or Location Cambridge			side City Limits			
3	with the 8 or 28 be no	Director	10e. Street and Number 1319 Hudson Road	10f. Zip Code	10g. C	itizen of What Country?				
7	Jeath	Funeral	13.19 HUGSON ROAQ 11. Marital Status 12. Was Decedent Ever in U.S.	21613	Ves or No.	USA 14. Race - American Inc	dian			
036	urs after o	b	Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? (Specify New York, Specify Cuban, Mexican, Puerto Rican 1 ☐ Yes 2 X No Specify:	etc.)	Black, White, etc. Specify: White				
Maryland 21215-0036	should be filed within 72 hours after death with the Marylar of Mental Hygiene. markad other than "naturel", or Items 23e or 28a-1 show matic event, the Medical Examinar must be multiled at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. F	Kind of Business/Industry				
22	filed wi Hygien other th	Con	11 17. Father's Name (First, Middle, Last)	farmer		agriculture				
land	ld ba f ental P kad of	To Be	Williams Steel Wheatley			Middle, Maiden Sumame)				
ary	2 should and Men Is marka aumatic	-		Eva May S . Mailing Address (Street and Number or Rural Rou		or Town, State, Zip Code)			
	s 1 and 2 should if Health and Men item 27 Is marka other traumatic		Radcliffe Wheatley son	5548 Cassens Neck Rd., C						
	Pages 1 nent of H int: If ite		1 Surial 2 ☐ Cremation 3 ☐ Removal from State	Disposition (Name of Date ry, crematory or other place)		ocation - City or Town, St	tate			
saitimore,	permit. Pages Department of Important: If i any injury or once.		' 4 □ Donation 5 □ Other (Specify) Green 21. Signat	Bank Cemetery 3/26/05 22. Name and Address of Facility Thoma		mbridge, MD				
Ď	Per Imp		John Jerou	700 Locust St., Cambr			•			
	Physician /Medical Examiner		23a. Part. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions	Menal Cell Carcin		Inten	oximate val Between et and Death			
,00,70	death certificate be axecuted e attending physician and of for use as the burial-transit	dical Examiner	Sequentially list conditions, Lary, loading to manufacture cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the conseque							
.O. DO	death certif e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day	Year			
o (chilo	quires that the dein signad by the auld be detached for	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		use contribute to the caus				
200	kicien: The law requires that the certificate has been signad by th rector, page 2 should be detache	Completed			4a. Was an autopsy performed?	24b. Were autopsy fine prior to completio death?	n of cause of			
	cten: ertifica ector, p	Bec	25. Was case referred to medical examiner?	26. Place of Death (Chec	□ Yes 🎉 🖎 No ck only one)	1 ☐ Yes 22 N	0			
	Phys this ral di	은	1		Residence escribe how injur	6 ☐Other (Specify)				
	2011	Certification:	€ Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fan building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No m, street, factory, office 28f. Lo	cation (Street an ty or Town, State	d Number or Rural Route	Number,			
1	lo the Hospitel or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	ledical Ce	29a. Certifier (Check only one) Medical Examiner: On the basis of my knowledge, and manner stated.	death occurred at the time, date and place, and du	a ta the gauge(s)	,	usa(s)			
	o the	Med	one) and manner stated. 29b. Signature and title of certifier ,	29c. License number		te signed (Month, Day, Ye				
1	- ≯⊢ ŏ	П	· Guerra / bus 55	H51792	3/.	20/65	· · · · /			
			30. Name and address of person two completed cause of death (Item 23a) (1	Type, Print)	1	4/->	1			
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	203 Dyin 77 Car	mbri dige	MP 2/61	3			
	Star Registra		MAR 2 4 2005		,					

			For State Registrar	State of Mar	yland		artment tificate			ınd M	ental H	ygien Reg. N	7000	12	28.3.	
	Physici /Medic		Decedent's Name (First, Middle, Last FAY)	WEB:	ER				1	2. Date of D Month IARCH	D	ay Year 2005		of Death	
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,		Location o			4	c. County of De	ath TGOMER	17	
Ī	Funeral Director		SUBURBAN HOSPITAL 5. Social Security Number 6. Security Number	7. Age ((In yrs. las	t birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs.	8. Date of E (Month, L FEB 7,	Day, Year	9. B	irthplace (State Country) W YORK		
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND MONTGOM		10c. City, 1	Town or Lo	cation COCKVI	LLE						10d. Inside	City Limits	
	with the a or 28a be notif	Direc	10e. Street and Number 5117 BRENTFORD DR	TVF			10f. Zip)852			10g. C	itizen of What C			
036	be filed within 72 hours after death with the Maryland Hygiene. Id blygiene. Id other than "natural", or flams 23a or 28a-f show avent. It's Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:			Was Deced f Yes, spec	lent of Hi		gin? (Spe , Puerto I	cify Yes or N Rican, etc.)	40-	14. Race - An Black, Wh Specify:	nerican Indian,		
21215-0036	within 72 hor ene. than "natura ne wed call	Completed	15. Decedent's Edi (Specify only highest grad			16a. Deced (Give life. I	dent's Usua kind of wor DO NOT us	al Occupa rk done d se retired	ation during most)	t of workii	ng	16b.	Kind of Busines			
O	should be filed nd Mental Hygia marked othar matic avent, II	a	10 17. Father's Name (First, Middle, Last) REUBIN SATZ			OHI	JIQC		18. Mothe		(First, Midd		on Surname)			
Mary	nd 2 sho alth and 1 27 is ma rr traums		19a. Informant's Name/Relationship (7) SEYMOUR WEBER/HUS										or Town, State, MARYLA		852	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If itam 2 is marked any injury or other traumatic av once.		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify)		cem	etery, crer	sition (Name thatory or of EMORIA	ther place	ons 3		ate 2005		Location - City of MAR			
Balt	permit. Departr Importa any inje		21. Signature of Funecal Service Licen	\$ 00		D2 11	Name an NZANS 170 RO	d Addres SKY-(OCKV	GOLDB ILLE	ERG I	MEMORI , ROCK	AL C	HAPELS, E, MARY	INC.	20852	
	Physician /Medical	and the second	23a. Part 1. When the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):													
	Examiner and II-transit	xaminer	Sequentially list conditions, if any leading transmission cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CORONARY Due to (or as a control of the control	onsquer	nce of/r 'AILUF		E								
8760,	cate be executed physician and the burial-transit	dical E	L	d. SEPSIS												
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal de	eath 3	Ectopic pr Other (sp						23d. Date of d Month	elivery Day	Year	
	quires that n signed b uld be deta	by	Part II. Other significant conditions co	entributing to death but	not resulti	ng in the u	nderlying c	ause give	en in Part I.				use contribute			
Division of Vital Records,		Completed									24a. Wa au pe 1 \(\text{Yes}	opsy form e gi?	prior to	autopsy finding completion of s 2 No	gs available I cause of	
Zita Zita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 X Inpatient	2 🗆 E	VOutpatier	nt 3 DC	Othe	25		(Check only		6 ⊡Other (Sp	nacify)	-	
ion of	ding After fune	\vdash	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)		8b. Time of Injury		8c. Injury Work	at	2			ury occurred	SCIIY)		
Divis	l or At after o Diraci	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home (Specify)	e, farm, str	eet, factory	, office				(Street a	and Number or i te)	Rural Route N	umber,	
	To tha Hospital or At within 24 hours after of To tha Funaral Dirac completely filled in by	edical		ysician: To the best of liner: On the basis of e and manner state	xaminatio							e, date a	nd place, and d	ue to the cause		
	To tha within 2 To tha complei	M	29b. Signature and title of certifier	10 V. C)	Posy	14		. License 0473	30				ate signed (Mo 3/2005	nth, Day, Year)	
	>		30. Name and address of person who of THOMAS V. JOSEPH,	MD 50 WES	T EDN	MONST	ON DR	IVE,	ROCK	VILL	E, MAI	RYLAN	ND 2085	52		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 25 20	Registrar	's Signatur	· Ass	de									

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		For State Registrar	State of Ma	aryland	•	artment of H <i>rtificate of I</i>			0000	10001	
_		Registrar 1. Decedent's Name (First, Middle, L.	ast)		Cer	lineate of t	Jean	2. Date of Dea	th	3. Time of Death	
Physicia /Medic		Josephine Lor	etta Wiley					March 2		10:53 am	
Examin	er	4a. Facility Name (If not institution, gi				_	Location of Death	1	4c. County of Dea		
		Reeder's Memor		e (In yrs. las	t hirthday)		nsboro If Under 24 Hrs.	8 Date of Birth		shington	
Funeral Director		214-09-4211	1□M XXF	88	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Aug. 28,	Year) C 1916 N	thplace (State or Foreign puntry) Mary land	
land W		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits	
Mary -fsh	ţō	Maryland Wash	ington		Wil	liamspor	t			1 Yes 2 □ No	
h the	Director	10e. Street and Number	i iig i o ii			10f. Zip Code		1	Og. Citizen of What Co	ountry?	
th wit	aiD	210 S. Artiza	n St.				1795		USA	1	
er dea	nue	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi		
s afte	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗖 I If Yes, Give Year or Dates:	No		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White	
P hour		15. Decedent's E	ducation	1 .	16a. Deced	dent's Usual Occup	ation		16b. Kind of Business		
hin 72 s. sn "na Med	pie	(Specify only highest gi	rade completed) College (1-4or 5	5+)	(Give lite. L	kind of work done of DO NOT use retired	during most of world)	king			
giene giene er tha	Completed	12				Assemble				an Manufactur	
be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las					_		Maiden Sumame)		
s should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after 33e or 28e-f show is marked other than "natural", or Items 23e or 28e-f show aumstic event, the Mcdical Examiner must be notified.	٩	Walter Raymond 19a. Informant's Name/Relationship	Roof		10h Mailin	Address (Ctroot	Emma	Elizabet	th Wade r, City or Town, State,	Zin Coda)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23e or 28e-f show eny injury or other traumatic event, the Medical Examiner must be natified at once.		Trudy Decker - D							vn,Maryland		
Heel Heel tem 2		20a. Method of Disposition	augirrei	20b. Plac	e of Dispo	sition (Name of natory or other place			20c. Location - City or		
Pages ent of ht: If i		1XXSurial 2 □ Cremation 3 l '4 □ Donation 5 □ Other (Spec			-			so 2005 V	Villiamenor	t,Maryland	
mit. F pertm sortei / inju		21. Signature of Funeral Service Lice	Y .	101 66		Spormedo				1, Mai y Tana	
Pe e la constant		(reintle	L	_					lliamsport,	MD 21795	
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused one cause on each li	d the death. ne.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death	
Physician		Immediate Cause (Final disease or condition	a ceru	mo V	na	in tec	iden	-		fee dos	
/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):						
	-	Sequentially list conditions,	b. Due to (or as	a consequer	nce of):						
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
be executed sicien and burial-transit		resulting in death) Last	Due to (or as	a consequer	nce of):						
ate be hysici	Icai	•	d					<u> </u>			
Attending Physician: The law requires that the death certificate in death. In death. ector: After this certificate has been signed by the attending physiby the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE:	220 Huga autoama	of programs	.,						
attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year	
the de y the iched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
s that	by PI	Part II. Other significant conditions	contributing to death b	ut not resulti	ng in the ur	nderlying cause give	en in Part I.	23e. Did tot	bacco use contribute to	the cause of death?	
w requires that been signed to should be deta	ed t	reperturi	an su	·zun	2	rock		1 □ Ye	es 2 No 3 P	robably 4 DUnknown	
ne law re has be ge 2 sho	Completed	failur &	think					24a. Was a	a. Was an 24b. Were autopsy findings available prior to completion of cause of		
The	Com							perform 1 ☐ Yes 2	ned? death?	2 □ No	
clan; sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	05	th (Check only on			
Phys this ral dir	. T	1 Yes 2 2 No	28a. Date of Inju	ent 2 EF	VOutpatien Bb. Time of	1 3U DOA	4 (Struising Fit		ence 6 Other (Spe	cify)	
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tel or s afte at Dir ed in	Certification:	4 [] Hornicide	building, et	(Opecity)					., 5.4.0)		
To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai		hysician: To the best miner: On the basis of and manner sta	f examination							
To the within Fo the complex	Me	29b. Signature and title of certifier				29c. License			9d. Date signed (Mont		
		-17	~0			D (8	१०१५	29	MARCH Z	5,2005	
5H-1		30. Name and address of person who					MD 217/1	n 301_	739-7100		
Sta	te	Dr. Vasant Datta 31. Date filed (Monthy dar Yaar)	34U VIT I I S 32. Registr	ar's Signatur	e Πd!	gers LOWII.	110 C1/4	0 301-	,05.7100		
Registr		1 MIN 29	2005	so B	· do	celle					
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The Section of Description of Descri				1. Decedent's Name (First, Middle, L	ast)			-				Day	Year	3. Time of Death
## Courty of Deam Predertick				Ge	cald	Charle	es S	Yonetz	Sr.			26	2005	11:55p ^M
Solicity Security Numbers Size				4a. Facility Name (If not institution, g	ive street and nu	mber)		4b. City, Town,	or Location	of Death		4c. County	y of Death	
Qualified Recovery Description The State Doc Control														
100. Colors 100. Colors	E									Min. Jun	ate of Birth Month, Day, 1 1e 16,	1920	Counti	(y)
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The state of period who completed cause of death (Item 23a) (Type, Print) RICHARD OFFEL ADDO MD 400 W SEVENTH STREET FREDERICK MD 21701 State 31. Date filed (Month AR Year) 9 2005 32. Figistrar's Signature		len: rtifica stor, p	O						26. Place			2110		A
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The state of period who completed cause of death (Item 23a) (Type, Print) RICHARD OFFEL ADDO MD 400 W SEVENTH STREET FREDERICK MD 21701 State 31. Date filed (Month AR Year) 9 2005 32. Figistrar's Signature		e Fun e Fun etely	dica	(Check only 2 Medical Exa	miner: On the b	asis of examina	ition and/or in	vestigation, in my	opinion, dea	ath occurred at t	the time, date	and place,	and due to t	he cause(s)
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30. Name and a fress of person who completed cause of death (Item 23a) (Type, Print) RICHARD OFFEL ADDO MD 400 W SEVENTH STREET FREDERICK MD 21701 State 31. Date filed (Month AR Year) 9 2005 32. Figistrar's Signature				1 400 Katako 1	ND 1	HOSPIT	ALIST	- D00	592	83	m	ARIL	27	2005
MAR 2 9 ZUU		x,		30. Name and a ress of per on who	completed cau	se of death (Item	п 23а) (Туре,	Print)		September 1	2000		1	
MAR 2 9 ZUU	1	<u>ر</u>			ADDO.	MD.	400	W. SEV	ENTH	H STRE	ET F	REDEP	ich N	10 21701
				31. Date filed (MonMAR Y2")	2005 32.	egistrar's Signa	ture	Scott .			,		*	

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) CLIFFORD GILMORE ALLEN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	2. Date of								
/Medical CLIFFORD GILMORE ALLEN	Month	f Death Day Yea	3. Time of Death						
Examiner 4a. Facility Name (If not institution, give street and number)	APRII		3:12P ^M						
	ocation of Death	4c. County of De							
COLLINGTON NURSING HOME MITCHELLY Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If			E GEORGES						
Director 235.03.9781 XX 90 Yrs. Months Days F	Hours Min. (Month	Birth 9. E (20, 1915)	lirthplace (State or Foreign Country) WV						
C > 100 Court			10d. Inside City Limits						
MD PRINCE GEORGES CHEVERLY 106. Street and Number 106. Zip Code		10g. Citizen of What	1 Yes 2 No						
(b) 2 Code C		USA	oountry :						
3116 LAKE AVE 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 No	anic Origin? (Specify Yes or Mexican, Puerto Rican, etc.)		nencan Indian,						
To Never married 2 married 1 yes 2 No If yes or Dates:	Mexican, Puerto Rican, etc.) Specify:	Black, Wi							
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 17b. Decedent's Education (Give kind of work done during life. DO NOT use retired) 17c. The state of the sta	on	16b. Kind of Busines							
(Specify only highest grade completed) [Specify only highest grade completed) [Give kind of work done during life. DO NOT use retired) [Specify only highest grade completed) [Give kind of work done during life. DO NOT use retired)	ng most of working								
SAFETY ENGINE		MINE SAFE	TY COMPANY						
The part of the pa	3. Mother's Name (First, Mid MARY ALICE MU								
JOHN HERBERT ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and JUDY ZANE 3116 LAKE AVE 20a. Method of Disposition 20b. Place of Disposition (Name of complete to complete the prince)			Zip Code)						
≥ g̃ ≡ b z JUDY ZANE 3116 LAKE AVE	CHEVERLY, MD	20785							
	Date	20c. Location - City of							
POLING+ST. CLAIRE F. 21. Signature of Juneral Service Licensee 22. Name and Address of FINK FUNERAL	of Facility	BUCKHANNON	I, WV						
TO COPPOSE PRODUCTION	L HOME, P.A. VY SW GLEN BU	DNTF MD 210	161						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failule. List only one cause on each line.	uch as cardiac or respirator	y arrest,	Approximate						
Physician Immediate Cause (Final disease or condition Rewrit Serviv			Interval Between Onset and Death						
/Medical resulting in death) Due to (or as a consequence of):	•								
Sequentially list conditions by Sart Valve Lad s	cordidio		- FEETH						
if any, leading to immediate Due to (or as a consequence of):	Due to (or as a consequence or):								
rainy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):									
seause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.									
ilicate and physical and physic									
Solution of the page of the pa		23d. Date of de Month	elivery Day Year						
	Part I. 23e. Di	d tobacco use contribute	to the cause of death?						
So so so so so so so so so so so so so so			robably 4 Dinknown						
Conjustice from the pleted to the contract of the colores	24a. W	as an 24h Were a	an 24b. Were autopsy findings available						
A se se se se se se se se se se se se se	autopsy performed?								
The state of the s	1 ☐ Yes		s 2□ No						
1 □ Inpatient 2 □ ER/Outoatient 3 □ DOA Outel. 4	4 Nursing Home 5 □ Re		ecify)						
27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work?		ribe how injury occurred							
2 Accident investigation M 1 Yes									
Comparison of Death Comparison of Death	28f. Location City or 7	(Street and Number or R own, State)	lural Route Number,						
29a. Certifier 29a. Certifier 1 Check only 29a. Certifier 1 Medical Examination to the best of my knowledge, death occurred at the time, do	Into and place, and due to the								
27. Manner of Death 1 Datural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (check only one) 29b. Signature and title of certifier 29c. License num 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 28a. Date of Injury 28b. Time of Injury M 1 Yes 28c. Injury at Work? 1 Yes 28a. Place of Injury - At home, farm, street, factory, office 28b. Place of Injury - At home, farm, street, factory, office 29c. License num 29c. License num	n, death occurred at the tim	e, date and place, and du	s stated. e to the cause(s)						
		29d. Date signed (Mon	th, Day, Year)						
D250	9 50	4/8/00							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don H. Yold I now HZ M2 7401 Executive	place La		20706						
State Registrar 31. Date filed (Month, Day Year) 1 2 200 532. Registrar's Signature									

		•	For State Registrar		State of M	•	epartment of H Certificate of		Mental Hy	giene Reg. No		12287	
	2		1. Decedent's Name (I	First, Middle, La	st)				2. Date of De Month	Da	y Year	3. Time of Death	
	Physici /Medic		Helen Louise				Abraham Apr				005	3:00 p M	
	Examin	er	4a. Facility Name (If no	ot institution, giv	e street and numbe	7)	4b. City, Town, o	r Location of Death	1	40	. County of Death		
		٠	5, Social Security Num		on Avenue	ige (In yrs. last birtl		ndon If Under 24 Hrs.	8. Date of Bir	rth	Baltime 9. Birthr	ore place (State or Foreign	
	Funeral Director		220-18-765	1	□M 2⊠F		rs. Months Days	Hours Min.	(Month, Da	ay, Year)	Cou	ryland	
	- 1		Usual Residence of De										
	arylan show	_	10a. State	0b. County		10c. City, Town	or Location					10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	88-f.	900	MD		timore		Glyndon 10f. Zip Code			100 Cit	tizen of What Cou		
	with t	ă	10e. Street and Number		- a t a m A * * * * * * * * * * * * * * * * * *			1071		rog. Ca	U.S.A.	itiy :	
	leath	Funeral Director	4204	WOLLIIII	ngton Aver	nt Ever in U.S.	13. Was Decedent of H If Yes, specify Cub	1071 Hispanic Origin? (S	pecify Yes or No)-	14. Race - Americ		
36	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28e-f show event, I.e Madral Examiner must be notilled at	by Fun	1 Never Married		Armed Forces 1 Yes 2 If Yes, Give Year or Dates	X No	If Yes, specify Cub 1 ☐ Yes 2 🖾 No		o Hican, etc.)		Black, White,	otc. √hite	
21215-0036	2 hou	ted		5. Decedent's E		16a.	Decedent's Usual Occup	ation during most of wor	kina	16b. K	(ind of Business/In	dustry	
218	thin 7	Completed	Elementary/Second		College (1-4o	r 5+)	(Give kind of work done life. DO NOT use retire		Kii i g				
S	filed withli Hygiene. other than	S			2 Yrs		Secretary		no (First Adiabata	A do ido o	Constru	iction	
and	ould be fill Mental H sarkad ott satic even	Be	17. Father's Name (Fit	rst, middle, Last, illiam F		1		18. Mother's Nan					
Maryland	2 should be filed wo and Mental Hygie Is marked other transcriber to rematic event, III.	2	19a. Informant's Name				Mailing Address (Street		ie Maxwe			Code)	
Ma	s 1 and 2 should f Health and Men flem 27 is marka other traumatic					l an	CONTRACTOR OF THE PARTY OF				2.20	2227	
ē,	s 1 and 2 if Health Item 27 other tra		20a. Method of Dispos	sition		20b. Place of	4204 Worthi Disposition (Name of c, crematory or other pla		Date	20c. L	ocation - City or To	own, State	
Baltimore,			1 ☐ Burial 2 🔯 (`4 ☐ Donation 5]Removal from Stat (y)	8 1	1 Cremation		2/05	Hamp	stead, N	Maryland	
alti	permit. Page Department of Importent: If any Injury of once.		21. Signature of und	ral Service Lice	Ssee C	2 -	22. Name and Addre	ss of Facility 1	1824 Rei	iste	rstown Ro	oad	
m	Depa Impo any I		101	TX	0/		Eline Fun				town, MD	21136	
			23a. Part1. Enter the shock, or heart f	disease, or com ailure. List only	plications that caus one cause on each	ed the death. Do n line.	ot enter the mode of dyli	ng, such as cardiad	or respiratory a	ırrest,		Approximate Interval Between Onset and Death	
	nysician .	K U	Immediate Cause (Fir disease or condition	nal	a	Myolo	dial Infor	cho				5 minites	
	/Medical Examiner		resulting in death)	(Due to (or a	as a consequence of	f):						
		er	Sequentially list condi	itions,	b. Due to (or a	as a consequence of	f):						
11/	nted Insit	min	cause. Enter Underly	ing							- 3		
1	s be executed sician and burial-transit	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):										
68760,	ite be iysicia ne bur	icai			_ d								
. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ician/Med	Physician/Med	IF FEMALE: 23b. Was decedent print the past 12 minths 12 Minths 2 Minths 12	onths?	4□Pregnant	2 Fetal death at time of death	3 ☐Ectopic pregnanc	y			23d. Date of deliver	ery Day Year
P.0	that the de led by the a detached f	hys	9 🗆 Unknown		9□ Unknown								
S,	es tha igned be de	by F	Part II. Other significa	ant conditions	contributing to death	but not resulting in	the underlying cause give	ren in Part I.			_	he cause of death?	
ord	w requir been si should I								10	Yes 2	Muo 3 Helor	oably 4 □Unknown	
Records,	e law r has be je 2 sh	Completed							24a. Was	psy	prior to co	ppsy findings available impletion of cause of	
<u>=</u>	: The l	Con							1 ☐ Yes	ormed?	death? 1 ☐ Yes	2 No	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred examiner?		Hospital:		Ott	26. Place of Dea			- 500		
of	Phys this aldi	. To	1 ☐ Yes 2 No.		1 ∐ Inpa	itient 2 ER/Out		ner: 4 □ Nursing H	28d. Describe			ý)	
on	iding I th. After funer	tion		5 Pending investigatio	28a. Date of In (Month, E	Day Year) In	77	rk? Yes 2 □ No					
Division	f or Attency after death Director: In by the	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify)					office 28f. Location (Street and Number or Rural Route Number City or Town, State)			al Route Number,		
_	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medicai Co				of examination and	death occurred at the ti						
	omple	Me	29b. Signature and titl	le of certifier			29c. Licens			29d. Da	ite signed (Month,		
	->-0		•	12-	, ,	1.0.	Da	053955			4/11/20	05	
	h		30. Name and address		4	f death (Item 23a) (Type, Print)					2 2	
	'/		Bim		har, H.D.		Falls Ra	#325	Lutheru	le,	MD 210	75	
1	Sta	-	31. Date filed (Month,		1	strar's Signature							
	Registr	ar		ADD	1 9 2005	Z.	H. Sperke						
Dille	/IH 17 Rev 1/2	004		RILL	1 % 2007	Marie San	S. GOWEL						

HOLLLS ALMONY nd 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 3 per phys 8842 4-14-05 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Almon **Physician** 7:30 AM 2005 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Oakway Imonion If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 18 M 2□F Months 72 4642 Director 21532 Feb. Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar court be notified at 1 ☐ Yes 2 🛛 No Director MO Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 58 Oakway Road 21093 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iter any injury or other traumatic event, the Medical Examining ODEs. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 N/AOperating Engineer Heavy Equipment 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hollis Almony, Sr. Mary Nolte 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol H. Almony/Wife 58 Oakway Road Timonium, MD 21093 20b. Place of Disposition (Name of cometery, crematory or other place)
Dulaney Valley
Memorial Gardens April 11, 2005 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, MD ' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
Michael J. Flagle 10 W. Padonia Road Timonium, MD 21093 23a. Part 1. Shert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Muocard /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executs.) Due to (c. as a consequence of) Examiner The faw requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 5 Residence 6 □Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier DU05710S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

Sarah F. Whiteford,

31. Date filed (Month, Day, Year) APR 1 32. Refistrar's Signature

Call House

M.D. 6565 N. Charles Street Suite 613 Baltimore, MD 21204

		•	For State Registrar	State of Marylan		rtment of F			iene 005	12289
ı	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	Mabel Eli	zabeth	Althoff		2. Date of Dear		3. Time of Death 10:25 A.M
	Examin		4a. Facility Name (If not institution, give s Alice Manor N 5. Social Security Number 6. Sex	ursing Home	last birthday)	4b. City, Town, or Baltime If Under 1 Year Months Days		8. Date of Birth	4c. County of Death	place (State or Foreign
	Director		212-07-9176 1□ Usual Residence of Decedent 10a. State 10b. County		Yrs.		Hours Min.	July 15		y I and 10d. Inside City Limits
	the Maryla 28s-1 sho	Director		imore			hite Hall		Og. Citizen of What Cou	1 □ Yes XX No
	23a or	rai Dir	2411 Garrett Road			2116	51		U.S.A.	
036	ours after des al', or Items Exercities l'in	by Funeral	11. Marital Status XX Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 □ Yes Y X XVo If Yes, Give Year or Dates:	11	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amen Black, White Specify: Whi	, etc.
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Memlarl Hygiene. Is marked other than "natural, or Items 23a or 28a-f show aumatic event, the Medical Exertive transtice multified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Deced (Give I dife. L Sec	lent's Usual Occup kind of work do ne DO NOT use retired retary	ation during most of worki d)	ing	16b. Kind of Business/li Commercia	·
land	should be filed nd Mental Hygi marked other imatic event, I	To Be C	17. Father's Name (First, Middle, Last)	Joseph F.	Altho:	ff	18. Mother's Name	e (First, Middle, I Hughes	Maiden Surname)	
2	as 1 and 2 should to the stand and Ment of Health and Ment I tem 27 is marked to ther traumatic et		19a. Informant's Name/Relationship (Type Mary P. Streeter		2411	Garrett	Road Whi	ite Hall	, City or Town, State, Zi	
Baltimore,	Paga ment ant: If ury o		20a. Method of Disposition XXBurial 2 □ Cremation 3 □ Re `4 □ Donation 5 □ Other (Specify)	emoval from State 20b. F	Place of Disposemetery, crem Anthor	sition (Name of natory or other place ny's Ceme	etery 4/8/	Date /5	20c. Location - City or T Emmittsbur	
Ball	permit. Departimports any inj		21. Signature of Furteral Service License	sentin	B ²² 36	Name and Addre	ss of Eacility SS—Seitz I Road Ba]	Tuneral to, MD	Home Inc.	
	death certificate be executed e attending physician and e attending physician and of for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	uence of):	D. 0		or respiratory arr	est,	Approximate Interval Batween Onset and Death
O. Box	the death certific y the attending p sched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3 🗌	Ectopic pregnancy Other (specify)	, ,		23d. Date of deliv Month	rery Day Year
rds, P	quires that the de in signed by the a uld be detached i	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.		oacco use contribute to es 2 □ No 3 □ Pro	_
	: The law requires that the cate has been signed by th page 2 should be detache	Completed						24a. Was a autops perform	y prior to co	opsy findings available ompletion of cause of
	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 Nursing Ho		e) ence 6 □Other (Speci	ify)
ion of	anding Phath. or: After the funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	y at k? Yes 2 □ No	28d. Describe ho	ow injury occurred	
DIVISION	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number or Rur n, State)	al Route Number,
	To the Hospitel within 24 hours of the Funerel I completely filled	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tire occurred	ne, date and place, pinion, death occurr	and due to the cared at the time, d	ause(s) and manner as a ate and place, and due	stated. to the cause(s)
	To the comp	M	29b. Signature and title of certifier	N	MD	29c. Licens	e number	2	9d. Date signed (Month,	
8	-1		30. Name and address of person who con SHOA113 A W	Thm 8	23a) (Type, I	Print) Enlan	0 87 8	ntc-30	8, Bout	my 2/20
	Sta Registr	6	31. Date filed (Month, Day, Year) APR 1 2 2005	32. Registrar's Signa	ture	W.				

State of Maryland / Department of Health and Mental Hygiene 05 1 - For Stata Ragistrar Certificate of Death Rag. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** 7:46 PM LOUIS BLOCKINGER MARTIN APR 10 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 900 CATON AVE, ST. AGNES HEALTHCARE N/ABALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Dec. 12,1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 12 M 2□F Hours Maryland 219-22-3981 76 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State rthan "neturel", or Items 23a or 28e-f show Ite Medical Examiner must be notified at 1 Yes 2 No N/A Baltimore Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21223 820 S. Caton Avenue Apt. 8F by Funeral Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 No Saltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within in and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Moving Company 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomasina Metzler Charles W. Blockinger 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 st of Health ar 1103 Carroll Street, Baltimore, Maryland 21223 Deborah McManaway Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages Depirtment of Important: If it any Injury or o 1 Burial 2 Cremation 3 Pemoval from State Cedar, Hill Cem. 04-14-05 Baltimore, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License McCully-Polyniak Funeral Home P.A. 130 E. Fort Avenue, Baltimore, Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC LUNG CANCER UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIOMYUPATHY UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): PNEUMONIA UNKNOWN burial-tran Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 menths? 4□Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 21 No 1□ Yes 2□No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending J □ Natural 1 Yes 2 No investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one) the 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P18616 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVENUE, BALTIMORE PRIYANKA NEUDRI 900 R 12 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last **Physician** Apri 2005 10:30 M ames /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of Baltimore Hospita Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreig.
 Country) **Funeral** Days 1 XM 2□F Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other then "natural", or Items 23a or 28a-f show traumatic event, if a Medical Ever in at traist be neithed at 1 Ses 2 No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Maryland 21215⁴0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) ary (0-12) and Mental 19b. Mailing Address (Street and Number Importent: If item 27 Baltimore, Oa. Method of Disposition ö + Burial 2 ☐ Cremation 3 Removal from Stat 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Uremia **Physician** /Medical Renal Failu **Examiner** Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed Diabetes Due to (or as a consequence of): heart failure Completed by Physician/Medical attending 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an page 2 s autopsy 1 Yes 2 r: After this certifica e funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; To the Hospital or Attending Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 Yes 2 No Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific DOO 16221 0 April

State Registrar 31. Date filed (Month, Day, Year) APR 1 2 2005

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Sinai H
32/Registrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)

Hospital of Baltimore

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			For State Registrar	State of Mar		artment of I			giene 005	12292
			Decedent's Name (First, Middle, L.	ast)				2. Date of Dea	th	3. Time of Death
	Physic /Medi		MARTHA	J.	BeA	denkop	5	APRIL	Day Year	
	Exami		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town,	or Location of Deal	th	4c. County of De	
				Avenue			timore		N/	7
	Funeral Director			Sex 7. Age (In yrs. last birthday) 58 Yrs.	tf Under 1 Year Months Days		(Month, Day	Year) 9. B	rthplace (State or Foreign country)
			Usual Residence of Decedent		38			JAN 31,	1947 H.	ary/AND
	ylanc		10a. State 10b. County	n/ 1	Oc. City, Town or Lo					10d. Inside City Limits
	e Ma	cto	MARYLAND N	//A	BAITI	MORC				1 ′⊠ °Yes 2 ☐ No
	ith th	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What 0	
	ath w	Funeral Director	3009 ORLA.	,. 0			1234		W.5.	4.
	Item Item	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
336	urs af	by	3 Widowed 4 Divorced	1 Yes 2 No tf Yes, Give Year or Dates:		1 Yes 22 No	Specify:		Specify:	hite
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28e-f show to Madical Examither. sat the multified at	Completed	15. Decedent's E	ducation	16a. Deced	ient's Usual Occup	pation		16b. Kind of Busines	****
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Maryland	vuld be filed with Mental Hygiene. Brked other than atic event, Item	Be	17. Father's Name (First, Middle, Las				1 -	me (First, Middle, M		
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Ma	C1 c0 00		19a. Informant's Name/Relationship	1 4					City or Town, State,	
ē,	Health tem 27 other tr		20a. Method of Disposition	h <u> </u>	20b. Place of Dispo cemetery, cren	sition (Name of			to Mo 20c. Location - City o	21223
Baltimore,	0		1 ☐ Burial 2 ☐ cremation 3 ['4 ☐ Donation 5 ☐ Other (Special	Triannoval nomi State	BAYVIEW		1 (4 /	1/05	Balto.M	
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m	Depa Impo any ii		/ hul M.	Stool	17	Artley	HILLER-	3 tella	Falting	e MD 21234
			23a. /art1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the	e death. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
Æ	Pnysician		Im rediate Cause (Final	motes	Ltis mi	10 6 No.0	1 1100 11		In	Onset and Death
	/Medical Examiner		Msulting in death)	Due to (or as a c	onsequence of):	nsma	11.6611.1	ung ca	ncer	3/190
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	led Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter of interlying Cause (Disease or injury	Due to (or as a c	onsequence of):					
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8760,	death certificate be executed e attending physician and ad for use as the burial-transit	dicai		d						
9	tificat ig phy as th	ledi								
Вох	eath certific attending p	Physician/Me	tF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy	,		23d. Date of de	livery
	e dea the at ned fo	sici	in the past 12 months?	4☐Pregnant at tim 9☐ Unknown		Other (specify)	<u> </u>		Month	Day Year
P.0	that the de led by the a detached		9 ☐ Unknown ' Part II. Other significant conditions		et reculting in the con-	4.44		00- 0:41		
ds,	og og	d by	atti. Ottor signinoati conditions	contributing to death but h	or resulting in the or	ideriying cause giv	ren in Part I.	239. Dia too	acco use contribute t s 2 □ No 3 □ P	o the cause of death? robably 4 □Unknown
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ta	ician: Th certificate rector, pag	e C	25. Was case referred to medical				OC Disease of Days	1 ☐ Yes 2	No 1 Yes	2 □ No
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	ter this		27. Manner of Death	28a. Date of tnjury (Month, Day Ye		28c. Injur Wor		28d. Describe ho		City)
Division	Attending r death. sctor: After by the fune	Certification;	1 Natural 5 Pending 2 Accident investigation	n	, inquity		Yes 2 □No			
Ë	l or Att after de Direct I in by t	rtific	3 Suicide 6 Could not be determined		- At home, farm, stre Specify)	et, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
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	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier Certifying Pl (Check only one) Medicet Exer	nysicien: To the best of miner: On the basis of example and manner stated	amination and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as te and place, and due	s stated. a to the cause(s)
	omple	Med	29b. Signature and title of certifier	and manner stated	•	29c. Licens			d. Date signed (Mont	
)	> O		MAIN			02	sasy			
	\n		30. Name and address of person who	completed cause of death	ı (ttem 23a) (Type, F	Print)			1-7-05	-
_	Ψ		Carole Mills	900c	notion	ave B	ALT N	MD21	229	
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	4				
	Registr	ar	APR 1	LUUD These	es to p	josefi				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month 2 Dev GEORGE H. 10:30 PM **Physician** /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Locetion of Death 4c. County of Deeth Examiner Columbia Lorien Nursing Home Howard If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) **Funeral** 1⊠M 2□ F Director 215-10-4518 86 Aug 26, 1918 Maryland Usual Residence of Decedent permit. Pegas 1 and 2 should be filed within 72 hours efter death with the Maryland Deperment of Health and Mantal Hygiana. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical France. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Funeral Director Maryland Howard Columbia 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 6336 Cedar Lane Apt. 266 21044 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 Widowed 4 □ Divorced Year or Dates: 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Produce Manager 10 Food Market 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Valentine H. Backert Mary S. Menegle 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) George H. Backert, Jr. / Son 15 Stuart Mills Place, Catonsville, Maryland 21228 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Lake View Mem. Park 4 ☐ Donetion 5 ☐ Other (Specify) 4/14/05 Sykesville, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Puneral Service Licensel 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical ementia Years Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tes 2 NO this cartificete Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 28a. Date of fnjury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s after daath. 1 Yes 2 No investigetion 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours া 🔾 Certifying Physicfan: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated. (Check only 2 Medical Examiner: On the besis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number IOIL 2005 Juls of 53411 HPRIL MD 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Bonne 20715 Gallant Fux Ln #210 Shesadri 14300 31. Date filed (Month, Day, Year) 32. Registrer's agnature

DHMH 16 Rev 6/95

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Hospitel or Attending Physicien: To the Hospitel within 24 hours a To the Funeral C

DHMH 17 Rev 1/200

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

AC Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) March 31, 2005 29b. Signature and title of certifier 29c. License number OCME hi, mid 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 LING CI

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature Bleen & Sparke

			State of Maryland / Department of Health and No. 1 - State State Certificate of Death	Mental Hy	giene, Reg. No. 00	5 12295
	Physici		1. Decedent's Name (First, Middle, Last) William Edward Bassler	2. Date of De	Day Ye	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Suint Agnes Hey Hhcare Bulti-mor.	S.	4c. County of I	~
	Funeral Director		5. Social Security Number 16. Sex 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Sex 17. Age (In yrs. last birthday) 18. Months 19. M	8. Date of Bir (Month, Da Sept.	th 9. 1927 M.	Birthplace (State or Foreign Country) aryland
	nyland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	ith the Marylar or 28a-f ahow	Director	Maryland Baltimore Catonsville		40 0%	1 ☐ Yes 2X No
	th with t		10e. Street and Number 601 Maiden Choice Lane Unit 6 21228		10g. Citizen of Wha	t Country?
036	urs after dea el', or Items Examiner an	by Funeral	11. Marital Status 1	pecify Yes or No Rican, etc.)		American Indian, White, etc. White
Maryland 21215-0036	n 72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life, DO NOT use retired)	king	16b. Kind of Busin	ess/Industry
212	ges 1 and 2 should be filed within 7 to Health and Mental Hygiene. If item 27 is marked othar then "n or other traumetic evant, the Med	Somp	Elementary/Secondary (0-12) College (1-4or5+) 12 Golf Professional		Golf	
and	be file ntal Hy ad oth	Be			, Maiden Sumame)	
ıryla	should be nd Mental markad c	2	Charles I. Bassler Ethel M. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur			ite, Zip Code)
, Na	and 2 stalth ar		William E. Bassler, Jr. (Son) 2013 Edmondson Avenue			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trae once.		20a. Method of Disposition 1 ▲ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date	20c. Location - City	
Ē	artmen ortant: injury			-2005	Catonsvil	lle, Maryland
Ва	permi Depa Impo any i		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Home 1630 Edmondson Ave	e of Car	tonsville. Ma	, Inc.
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final September 2)			Approximate Interval Between Onset and Death
	/Medical Examiner		Due to or as a consequence of): Perforated diverticus	1.1		Duests
11/ 8760, pl	ate be executed hysician and the burial-transit	Ical Examiner	Sequentially list conditions, To ly leading to intrinsiciate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	liT15		Just 3
7		ס	IF FEMALE:			
.0. Box	deatl	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of Month	f deliv <i>e</i> ry Day Year
// /// ords, P	The law requires that the tie has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contribu Yes 2	te to the cause of death? Probably 4 Unknown
Pec Rec		Completed		24a. Was autor perfo 1 Yes	osy prior deat	e autopsy findings available to completion of cause of th? Yes 2 \(\subseteq \text{No} \)
5/e Vital	Physicien: The this certificate har director, page	Be	25. Was case referred to medical examiner? Hospital: Other: Other:			
) 455 on of	Jing Ph J. After th funeral	Ilon: To	27. Manner of Death 1		dence 6 Other (Specify)
β_{a}	I or Attending after death. Director; After I in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or Tox		or Rural Route Number,
	To the Hospital or Al within 24 hours after of To the Funerel Direc completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the red at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and tiple of certifier 29c. License number		29d. Date signed (M	
	7		18203		theri!	7,2005
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Green 900 S. Caten Avenue			
	Sta Registr		Andrew Green 900 S. Caten Avenue 31. Date filed (Month, Day, Year) APR 1 2 005			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) B. Time of Death Year Day April **Physician** John David Blumgart 9, 2005 6:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Casey House Montgomery Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 1, 1924 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1₩ 2□ F 111 22 3357 Yrs. 80 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 27 ie marked other than "naturel", or Items 23a or 28e-f show treumatic event, the Medical Externit et mast be notified al 1 ☐ Yes 2 X No Maryland Montgomery Rockville Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 5550 Tuckerman Lane United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1843 1 Never Married 2 Married White Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "na any injury or other treumatic event, If a Medic once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Economist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard Blumgart Alice Loomis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4109 31st St., Mt., Rainier MD 20712 J. David Blumgart (son) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Chesapeake Crematory 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 04-11-2005 Beltsville MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S 22 Name and Address of Facility Rapp Funeral & Cremation Service Steph Dohmann _ NE0382 933 Gist Ave Silver Spring MD 20910 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Congestive Heart Failure Physician Weeks resulting in death) /Medical Due to (or as a consequence of) **Examiner** Months End Stage Cardiac Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner ed by the attending physician and detached for use as the burial-transit certificate be executed Coronary Artery Disease years that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown n signed by th 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Chronic Obstrustive Pulmonary Disease Completed has been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2₩ No Division of Vital To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certified funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6XXOther (Specify) Hospice Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number 04-09-2005 D09470 1-20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre 10901 Connecticut Ave Kensington MD 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature Blan & Aparle Registrar

ORIGINAL

			State of Maryland / Departr 1- State of Maryland / Departr Registrar AMEND ITEM #6 PER FH G842 4 1976			- 211115	12297
	Divisio		1. Decedent's Name (First, Middle, Last)	Salffor Doalin	2. Date of Dea Month	th Day Year	3. Time of Death
	Physicia /Medic		James R BALDWIN		4	9 200	
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b.	. City, Town, or Location of I	Death	4c. County of Dea	th
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Under 1 Year If Under 24	Hrs. 8. Date of Birth Min. (Month, Day	1 9. Bir	thplace (State or Foreign ountry)
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	yland		10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
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	with th	Funeral Director		Of. Zip Code	1	log. Citizen of What C	•
	ns 23g	eral	83 Railroad Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21071 Decedent of Hispanic Origin	2 (Specify Yes or No-	U.S.A	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, the Medical Evantret must be rotified at ODEs.	by	Armed Forces? If Yes 1 □ Never Married 2 ▼ Married 1 🖾 Yes 2 □ No	s, specify Cuban, Mexican, F Yes 2⊠ No <i>Specify:</i>	Puerto Rican, etc.)	Black, Whi	
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Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	me and Address of Facility e Funeral Hom	11824 Rei	sterstown stown, MD	
Į,			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.				Approximate Interval Between
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	To the Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Director: After this certifica completely filled in by the funeral director, gompletely filled in by the funeral director in the fune		29a. Certifier **Certifying Physician: To the best of my knowledge, death occ	curred at the time, date and a	GUIN	an ma	enter and the state of the
	ne Hos n 24 h na Fur sletely	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigand manner stated.	gation, in my opinion, death	occurred at the time, d	ate and place, and du	e to the cause(s)
١	To t Within	Ň	29b. Signature and tyle of certifier	29c. License number 296371	2	9d. Date signed (Mon	th, Day, Year)
	104.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print		m Jt R	alhome	MD
	Sta	te	. 70.0		2 3		- 30
	Registr		APR 1 2 2005	ses.			

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31. Date filed (Month, Day, Year) APR 1 2 2005

30. Name and add

UPPLS. 32. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

OCME

111 Penn Street Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 9:05PM BROWNING BLANCHE NORMA HENRIETTA 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner BOL Franklin Square HOSP, tal Rosedon 1+1m0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months 1 □ M 2 🔀 F 92 Yrs. 385-01-2316 Director 8-31-1912 MICHIGAN Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits rel', or Items 23a or 28e-f show Examiner must be notified at MIDDLE RIVER BALTIMORE 1 Tyes 2 No MD Director 10g, Citizen of What Country? 10f. Zio Code 10e Street and Number U.S.A. 600 LANOITAN ROAD 21220 F. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Amed Folces: 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify Specify: WHITE þ 3 XWidowed 4 ☐ Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 8 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARY (BEYERSDORF) 0 JOSEPH KEANER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 0 Department of Health a Importent: If item 27 Is any injury or other tra once. 600 F. LANOITAN ROAD MIDDLE RIVER, MD JOYCE WAGNER/ DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4-11-2005 * 4 ☐ Donation 5 ☐ Other (Specify) CATONSVILLE, MD METRO CREMATORY 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE ROSEDALE. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Subdural Immediate Cause (Final disease or condition resulting in death) emotomor Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien; The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA P 1 Yes 2 No 28a. Date of Injury (Month, Day) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 4-00PM Certification: After 5 Pending investigation 1 Natural Fell while getting out of Bed 05 1 ☐ Yes 2 ☐ No 2 Accident in by the Director: 6 ☐ Could not be 28f. Location (Street an Number or B. Al Route Number, City or Town, State) 9000 Franklin 5000 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide building, etc. Hospital Franklin Drive Baltimore Square To the Hospitel within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

Orkinmons Ahmed 9066 Franklin square prive Baltimor

32. Registrar's Signature

Now &

31. Date filed (Month, Day, Year)

APR 1 2 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			Registrer 1. Decedent's Name (First, Middle, Las	0		illicate of	Dealit	2. Date of Deal	eg. No: UUU	3. Time of Death
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	Funeral Director		5. Social Security Number 6. Sec 218 - 22 - 3974	20191100	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birth 20, 1428	place (State or Foreign Intry)
	puq 🛦 💮		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or L	ocation			, ,,,,	10d. Inside City Limits
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	within to the To the Comple	Me	29b. Signature and title of certifier), 0		29c. Licens			9d. Date signed (Month	
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			30. Name and address of person who	completed cause of death (Iter	10X)(Type	Print) Print)	auneir	Modi	toril 11,2 cal Cent	er
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			for State Registrar	State of Ma	aryland / Dep	artment of He	ealth and M	_	_	e. D5 1230
	Physic /Medi Exami	cal	1. Decedent's/Name (First, Middle, I	ive street and number)	Barti	4b. City, Town, or L	Location of Death	2. Date of De Month April	1 Day 200	Death
	. Funeral Director		North Arundel House Security Number 212–52–3636 Usual Residence of Decedent	•	e (In yrs. last birthday 56 Yrs.	Glen Bu If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da June	th a	Arundel Birthplace (State or Foreign Country) MD
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f show importents of the marked other then "natural", or Items 23e or 28e-f show principly or other treumatic event, I'rs Marical Examiner must be natified at ance.	Director	Maryland Anne A	rundel	10c. City, Town or L	Pasa 10f. Zip Code			10g. Citizen of Wha	
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Baltimore,	iit. Pages 1 an triment of Heali stent: If item 2 njury or other		Bea M. Bartholon 20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Spec	□Removal from State	20b. Place of Disponentery, cre Maryland	main Aven position (Name of matory or other place) Veterans 2. Name and Address	Apri¶ Cem 200	ate 14 5	20c. Location - Cit	le, Maryland
			23a. Parf. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	Malle	(xed)	3111 Mour	ntain Roa	d, Pas	adena, MD	Pal Home, P.A. 21122 Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed in including the law requires that the has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as c.	a consequence of): Methoda consequence of): Modern a consequence of): Modern a consequence of): Modern a consequence of):	Information of	of the second			
.O. Box 6	at the death certifica by the attending phateched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
Records, P.	aw requires that s been signed b 2 should be det	Completed by P	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	nderlying cause given	in Part I.	1 🗆 `	Yes 2 □ No 3 □	autopsy findings available
	Physicien: The lav this certificate has ral director, page 2 a	Be Com	25. Was case referred to medical examiner?				26. Place of Death	1 Yes	prior deat 2 No 1	to completion of cause of
of	ting Phys	Certification: To	27. Manner of Death 1 Matural 5 Pending investigati 2 Accident Gould not	200	y Year) 28b. Time o	f 28c. Injury a Work?	at 2	8d. Describe I	dence 6 Other (S	
Divi	- 2 - 7		4 Homicide determine	building, etc	of my knowledge, deat	n occurred at the time	date and place a	City or Tov	vn, State)	r Rural Route Number,
	To the Hospitel or within 24 hours aft To the Funerel D completely filled in	Medical	(Check only one) 2 Medical Example 29b. Signature and title of certifier	miner: On the basis of and manner sta	examination and/or in	vestigation, in my opin	nion, death occurre	d at the time,	date and place, and	due to the cause(s)
	(0	1	30. Name and address of person who	1(1)	eath (Item 23a) (Type,	Print)	13654	3 n	1-0	→
las:	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2	32. P gistra	ar's Signature	and s	- 100			

			1 - State Registrar	State of Man	yland / Depa		Health and		ene 005	12302
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Merle Rack		Beach	er		2. Date of Death Month	10 05 Year	3. Time of Death 5:34 P M
	Examir		4a. Facility Name (If not institution, give stre		Constance	4	n, or Location of Dea		4c. County of Deatl	
	Funeral		5. Social Security Number 6. Sex	ledical (n yrs. last birthday)	If Under 1 Ye	apolis ar i If Under 24 Hrs	MD 8. Oate of Birth	Anne A	nplace (State or Foreign
	Director		444-26-4970 ^{1□ M}	2 ∑ F {	36 Yrs.	Months Day	ys Hours Min	8. Oate of Birth (Month, Day, April 29	Year) Co.	lahoma
	and w		Usual Residence of Decedent 10a. State 10b. County	10	oc. City, Town or Lo	cation				10d. Inside City Limits
	Maryli f eho	to	MD Anne Aruno		Annapo.					1 ☐ Yes 2 X No
	h the	Funeral Director	10e. Street and Number	ici	Ailiapo.	10f. Zip Code	e	10	g. Citizen of What Co	untry?
	23a c	raiD	909 Topmast Way				21401		USA	
	er de itams	nue		Was Decedent Eve Armed Forces?	r in U.S. 13. V	Was Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
980	urs aft	þ	1 ☐ Never Married 2 ☐ Married ☐ 3 ☐ Married ☐ Divorced	1 ☐ Yes 2XXXNo If Yes, Give Year or Dates:	1	□ Yes XX	No Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or itams 23s or 28s-f show he Medical Examinat nast be notified at	Completed	15. Decedent's Educati (Specify only highest grade co	ion ompleted)	16a. Deced	lent's Usual Occ	cupation	nking 1	6b. Kind of Business/I	ndustry
121	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)			ne during most of wo ired)		_	
	filed v Hygie other t		17. Father's Name (First, Middle, Last)		Secre	etary	18. Mother's Na	me (First, Middle, M	Governme aiden Sumame)	ent
<u>lan</u>	Mental Mental arked o	To Be	Clarence H. Lee				Alice	C. Willia	ms	
Maryland	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Stre	et and Number or R	ural Route Number,	City or Town, State, Z.	ip Code)
	s 1 and 2 of Health item 27		Carolyn S. Matthews 20a, Method of Disposition			Copmast	Way, Anna	polis, MD		
nor	Pages nent of H int: If ite		1 X Burial 2 ☐ Cremation 3 ☐ Rem	Oval Holl State	20b. Place of Dispos cemetery, crem				0c. Location - City or 1	
Baltimore,			* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Septice Licensee			Name and Add	etery 4-1		rentwood,	MD
ñ	permit. Departr Imports any inj		* Junger			Hardest 12 Rids	ty Funeral gelv Avenu	Home, P.	A. lis, MD 21	401
	Physician /Medical Examiner	ner	23a Park. Enter the disease, or complicate shock, or heart failure. List only one of limited the Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	Pheun Due to (or as a co	nothora	LX		c or respiratory arres	st,	Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medical Examiner	resulting in death) Last	Chroni Due to (or as a co	ic Lw onsequence of):	y Dis	sease			
.O. Box	that the death certifice led by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown	If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnal Other (specify)			23d. Date of delive Month	very Day Year
s, P	res that igned b	by Pl	Part II, Other significant conditions contrib			ndertying cause	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ord	v require been sig should b	ted t	Congestive Hea	urt Fain				1 🗆 Yes	2XNo 3□Pro	bably 4 Unknown
al Record	ding Physician: The law r n. After this certificate has be funeral director, page 2 sh	Completed	Coronary Arten	y Disea	ase			24a. Was an autopsy performe 1 \sum Yes 2	prior to co	opsy findings available ompletion of cause of 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	pital: 🕶			Othor	ath (Check only one)		
of	g Phys er this eral di	n: To		1 SInpatient 28a. Date of Injury	2 ER/Outpatient	28c. In	4 🗀 (40) 311 9 1	10me 5 ☐ Residen 28d. Describe how	ce 6 Other (Special injury occurred	fy)
ion	Attanding F r death. ector: After by the funera	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	aar) Injury		vork? ☐ Yes 2 ☐ No			
Division	Dir Dir	Certification:	4 Homicide	28e. Place of Injury building, etc. (S	Specify)			City or Town,		
	Hosp 24 hou Fune stely fi	Medical	29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner	an: To the best of m : On the basis of exa and manner stated	amination and/or inv	occurred at the estigation, in m	time, date and place y opinion, death occu	e, and due to the cau urred at the time, dat	se(s) and manner as a e and place, and due t	stated. to the cause(s)
	To the Hospital within 24 hours To the Funeral completely filled	Me	29b. Signature and title of certifier		1	29c. Lice	ense number	290	I. Date signed (Month,	Day, Year)
	d		> Zleely	1 Q.Z	terde.	MD TO	00622	296 1	24/10/pc	_
1	0		30. Name and address of person who comp	leted cause of death	(Item 23a) (Type, F	Print)		Α	1,-123	
1	<i>y</i>		31. Date filed (Month, Day Year)	Profe W	Signature	Medic	cal tarki	vay, A	nnapolis	, MD 2140
	Sta Registi		APR 1 2 2005	Recurs	H. Ave	de				

			1_ For	State of Maryland / De	epartment of Health and	Mental Hygi	ene
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of Death		g. Ma. UU5 123U3
	Physic	an				2. Date of Death Month	Day Yeer
	/Medi		Anna Mae Bogus 4a. Facility Name (If not institution, give s	street and number!	th City Taylor and another of David	April 4	
	Examir	ier	Laurel Regional Ho		4b. City, Town, or Location of Deal Laurel	ın	4c. County of Death
	Funeral		5. Social Security Number 6. Sex	···		8. Date of Birth	Prince George
	Funeral Director]M 2⊠F 78 Yr	Months Days Hours Min		Year) 9. Birthplace (State or Foreign Country) 1927 Pennsylvania
	how		10a. State 10b. County	10c. City, Town o	or Location		10d. Inside City Limits
	e Ma	ctor	MD Montgom	ery Silve	r Spring		1 ☐ Yes 2 ☐ No
	or 28)ire	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?
	23e	rail	3112 Cordoba Stree	t	20904		USA
	tems tems	nue		12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	ori	y Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2/1 No If Yes, Give	1 ☐ Yes 2X No Specify:		Specify: White
Ö	turei turei	d be	15. Decedent's Edu	Year or Dates:	and all the Constitution		
21215-0036	within 72 hours after death with the Maryland ane. then "neturel", or items 23e or 28e-f show to Moulcal Externities.	Completed by Funeral Director	(Specify only highest grade	e completed) ((ecedent's Usual Occupation Give kind of work done during most of wo ife. DO NOT use retired)	nking	6b. Kind of Business/Industry
12	filed with Hygiene. other ther	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	····,		
D	filed Hygid other ent, II	Be C	17. Father's Name (First, Middle, Last)	V	18. Mother's Na	me (First, Middle, M	laiden Sumame)
an	should be nd Mental marked o	To B	Stanley Linko			Stelmach	
Maryland	2 shou and M is mar eumet	-	19a. Informant's Name/Relationship (Ty	pe, Print) 19b. N	Mailing Address (Street and Number or R		City or Town, State, Zip Code)
	and 2 salth a n 27 is		William Bogus / So				Laurel, Maryland 20723
ľe,	es 1 and of Health filem 27 r other tr		20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other place)		Oc. Location - City or Town, State
Ë	Pages nent of I nnt: If its iry or o		1 XBurial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	dilloval il Otti State		12005	Silver Spring, Marylan
Baltimore,	보 된 본 분		21. Signature of Funeral Service Licens		22. Name and Address of Facility	Flech Fund	eral Home, Inc.
m	Depa impo any ii		MAGA	\Rightarrow	process and the second	Road. Lai	ree, Marykand 20707
B	Physician		23 Part1. Enter the disease, or compli- book, or hearn ailure. List only or Immediate Cau 3 Final disease or condition		t enter the mode of dying, such as cardia		st, Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of)			1 Month
	Examiner		Sequentially list conditions	Ostcoporosis			75 Years
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of)	:		12 121113
	acute ind trans	Examiner	Cause (Disease or injury that initiated events				
,092	e exe	Ë	resulting in death) Last	Due to (or as a consequence of)			
876	ate b hysic the b	lical		l			
x 68	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE:				
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month Day Year
o.	the a	/sic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)		World Day Toll
P.0	hat th od by detac	Ph	Part II. Other significant conditions cor	stributing to death but not reculting in the	no underkring enune gween in Root I	23a Did tob	acco use contribute to the cause of death?
ds,	ires that the death signed by the atte d be detached for	1 by		Disease, Chronic			s 2 No 3 Probably 4 Unknown
0	w requir been si should	etec	_	•	CON		
Records,	hast hast ge 2 s	ldu	Pulmonale, DV			24a. Was an autopsy	prior to completion of cause of
<u>a</u>	icien: The la certificate ha ector, page					perform 1 ☐ Yes 2	ed? death? XNo 1 ☐ Yes 2 ☐ No
Vital	ysicien: is certific director,	Be	25. Was case referred to medical examiner?	lospital: 🚜	Other	ath (Check only one	
of	Phys this ral di	-T	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 Inpatient 2 ER/Outp. 28a. Date of Injury 28b. Tin	ation 30 DOA 40 Indising i	tome 5 Resider 28d. Describe how	nce 6 Other (Specify)
UO	ding Phy h. After thi funeral	tlon	1 XNatural 5 ☐ Pending	(Month, Day Year) Inju	work? M 1 □ Yes 2 □ No	200. 200.100 1100	winjury occurred
Division	utten deat ctor: y the	Certification;	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm		28f Location (Str.	eet and Number or Rural Route Number,
Ξ	after Dire	erti	4 Homicide determined	building, etc. (Specify)	, street, ractory, office	City or Town,	State)
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) 1 Certifying Phys	ner: On the basis of examination and/	death occurred at the time, date and place or investigation, in my opinion, death occu	a, and due to the car arred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	thin 2 the mple	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number		d. Date signed (Month, Day, Year)
	₹ <u>8</u> ₹ 8		D 20	_ MD	D22755	29	
	15						4/4/2005
	1		30. Name and address of person who co			Mario	1 00707
	Sta	ato	31. Date filed (Month, Day, Year)	32. Redistrar's Signature	Dusen Road, Laurel	, marykan	a 20/0/
•	ા Regist		APR 1 2 7	32. Registrar's Signature	Aparle		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2005 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death SANO BALTEMORE TOWN N UTURE CARE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 10 M 20 F 218-09-1940 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 12Yes 2□No Md. RUTIMORE 10e. Street and Number 10g. Citizen of What Country? 2208 21216 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces: 1 by Yes 2 □ No If Yes, Give Year or Dates: / 943 - 46 1 Never Married 2 Married 1 ☐ Yes 2 ₺ No Specify: 3 Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Monthomery Waxels NIA RUCKCIREUER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) orym rani 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2072/ 19a. Informant's Name/Relationship (Type, Print) JONATHAN WENTHE, MI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 13/05 OUTNOS MIUS CLARKISON FOREST VA 22. Name and Address of Facility BUERTY D. CROMART 21. Signature of Funeral Service Licensee Terun Commute 2431 2 OLIVER ST. - BACTO. 23a, Part 1. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jusace or tripry) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? DIOMYOPATHY 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown

Physician /Medical Examiner

law requires that the death certificate be executed

page 2 should be

After this certificate has

or Attending

death.

efter death

within 24 hours e

filled in by

Certification: To

Medical

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

Funeral

Director

injury or other traumatic event, the Medical Examiner must be nutified at

Baltimore, Maryland 21215-0036

or Items 23a or

"natural".

marked other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth. any injury or other traumatic event 9068.

the attending physician and hed for use as the burial-transit

Examiner Physician/Medical IF FEMALE: þ Completed

23b. Was decedent pregnant in the past 12 months? 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS 24a. Was an

2 HNO

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 Yes 2 No

28a. Date of Injury (Month, Day Year) 5 Pending investigation

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Manner of Death

1 Natural

2 Accident

3 🗌 Suicide

4 Homicide

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

mp

29b. Signature and title of certifier Mar,

D0059107

29d. Date signed (Month, Day, Year) 04-12-2005

State Registrar 31. Date filed (Month, Day, Year) APR 1 2 2005

UMA

M-D



DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2600 LIBERTY HEIGHTS AVENME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BOSLEY, SR. 10:14 PM 05 2005 Phillip /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TARTORY MARFORD MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days t**∑**M 2□ F 218-26-7922 74 Director April 11,1930 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Harford Edgewood 1 ☐ Yes 2 X No Maryland Funeral Director the 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number filed within 72 hours after death with 21040 461 Buxton Court USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ty Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mentai Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Dairy Farming Laborer 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 shouid be f nent of Health and Mentai I ant: if item 27 is marked o Rhoda Pinkney Flowers Thomas Edward Bosley, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a I: if item 27 is or other trai 461 Buxton Court, Edgewood, MD 21040 Betty May Bosley/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Owings Mills, MD 4-13-05 * 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral, Service Licensee 1317 Cokesbury Road, Abingdon, MD 21009 Approximate Interval Between Onset and Death 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 2 MONTHS disease or condition resulting in death) /Medical Due to (or as a cur equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEMATO PNEWMOTHORAX 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate 1 Yes 2 No of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA Director: After the in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner ef Death Medical Certification: To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Momicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and tiple of certifies

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2005

31. Date filed (Month, Day, Year)

HAURE LEGIPTE MD 21078

	_1	For State Registrar	State of Maryland	Department of F Certificate of			giene 0 0 5 Reg. No.	12300
Physician /Medical		JOHN W. BROWN	1			2. Date of Dea Month APRIL	Day Year 07 2005	3. Time of Death
Examiner Funeral Director		Ia. Facility Name (If not institution, give MARINER HEALTH OI is. Social Security Number 214-12-0498	GLEN BURNIE	BROOKLY	N PARK If Under 24 Hrs. Hours Min.	8. Date of Birt	BALTIMO	
Maryland o-f show fled at		Jsual Residence of Decedent Oa. State 10b. County MD N/A		own or Location				10d. Inside City Lim 1 ☑ Yes 2 □
23s or 28e-f shows the relified at		Oe. Street and Number 901 CHERRY HILL F	COAD	10f. Zip Code 2122	5		10g. Citizen of What Co USA	untry?
Its after des N; or Items Carricle Fr	2	1 Marital Status 1 Never Married SM Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 19 43 - 1	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)		
ygiene. Net than "nature" t, the Medical E	- Louisian	15. Decedent's Edu (Specify only highest grad	College (1-4or 5+)	6a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired TRACTOR DRIVE	during most of work d)		16b. Kind of Business/	Industry
B s b B	מ	7. Father's Name (First, Middle, Last) JOHN BROWN				e (First, Middle, NIE EURY	Maiden Sumame)	
permit. Pages I and 2 should be important! If flem 27 is marke any injury or other traumatic once.		DAISY M. BROWN/WI DAISY M. BROWN/WI Coa. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	emoval from State	of Disposition (Name of otery, crematory or other place 2dar Hill 22. Name and Address	HILL RD,	BALTIM Date 13-05 MES A. 1	MORE, MD 212 OC. Location - City or MORTON & SO OKE, MD 212	225 Town, State NS F.H.,
the raw requires that the bearing entitled by sweated that has been signed by the attending physician and barial-transit and be detached for use as the burial-transit and by Physician/Medical Examiner	í	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Du	te Heart; tai luse tai luse Nalig	- Ch rang	e kronic : w.r	, kidny H met	Dislove Spain
ed by the attending p detached for use as		FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown				23d. Date of deli Month	very Day Year
been signed by should be detacted by Physical Inc.	ה '	Part II. Other significant conditions con	atributing to death but not resulting	g in the underlying cause give	en in Part I.		obacco use contribute to res 2 □ No 3 □ Pro	the cause of death?
cate has been signated as page 2 should	1	Recu	plent pr	enmone enpre	in why	24a. Was a autop perfor 1 Yes	sv prior to c	topsy findings availa ompletion of cause
tending ringstrain. tor: After this certific the funeral director. cation: To Be	2	25. Was case referred to medical examiner? 1	lospital: 1 □ Inpatient 2 □ ER/ 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify)	D. Time of 28c. Injury Work	/ at	ome 5 Resid	dence 6 Other (Special Communication of the Communi	
Funeral Funeral fely filled		29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my knowled ner: On the basis of examination and marrier stated:	ige, death occurred at the tin and/or investigation, in my o	ne, date and place, pinion, death occur	and due to the o	cause(s) and manner as date and place, and due	stated.
n 24 hours in Eunarel sletely filled	3							to the cause(s)
within 20 spirator of within 20 spirator after of the Funeral Direct completely filled in by Medical Certification of the complete of the comp		29b. Signature and title of certifier CARLOS M. P	nthe instruc	29c. Licenso			29d. Date signed (Month) APRIL 8, ARYCHNO	Day, Year)

	an	1. Decodent's Name (First, Middle, Last)	218	00)		2. Date of Deat Month	Day Ye	3. Time of Death
Medic		4a. Facility Name (If not institution, give	street and number)	JUT!	4h City Town o	or Location of Dea	March 2	9, 2005 4c. County of E	9:20 a
amin	er	Prince Georges			Chev		ш	P.	
eral		5. Social Security Number 6. Se	x 7. Age (In yrs.		If Under 1 Year Months Days			1	Birthplace (State or Fore Country) Wash D
ctor		577-58-3163 220-85-7770 Usual Residence of Decedent	² X F 5.8	Yrs.	World Buys	Tiours Will	07/16/1	946 t	G. Carolina
福		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Lim
Deili	ctor	MD Calvert		Lusby					1 □ Yes 2 □
DE UG	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	t Country?
Tust	ra	11484 Rawhide Roa		- 1.5		0657		U.S.	
iner	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 □ No	S. 13. V	Was Decedent of F f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, White, etc.
Exam	þ	3 Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	Black
edical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	lent's Usual Occup kind of work done	oation during most of wo	rkina	16b. Kind of Busin	ess/Industry
IF B. Mg	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retire	d) _	9		-1 7.
event, II		12th 17. Father's Name (First, Middle, Last)		<u> </u>	Reception		me (First, Middle, M	Animal S	Shelter
0	o Be	Archie Wigfall, S	r.				tie John	•	
emne.		19a. Informant's Name/Relationship (T)		19b. Mailir	g Address (Street	and Number or R	ural Route Number,	City or Town, Sta	te, Zip Code)
ŧ			on				White Pla	ain, MD	20695
or othe		20a. Method of Disposition 1 ☐ Burial 2XXC remation 3 ☐ F	Removal from State	lace of Dispo emetery, cren	sition (Name of natory or other place	сө)	Date	20c. Location - City	or Town, State
njury		`4 □Donation 5 □ Other (Specify)					6/2005	Riverdale	e, Maryland
any Ir		21. Signature of Juneral Service Licens	HOONGI.		. Name and Addre	300000 100 E	reeman Fi		
		23a. Part1. Poer the disease, or comp shock, or leart failure. List only	teations that caused the death				tland, Ma		20752 Approximate
cian		Immediate Cause (Final	ne cause on each line.						Interval Between Onset and Death
cal		disease or condition resulting in death)	a Pneumonia Due to (or as a consequ	uence of):					
ner		Sequentially list conditions.	Lung Cance	r					
	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					
al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of);		-			
the burial-transit	dical		4						
CO CO	ě								
for use as t	cian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy	V		23d. Date of	,
ped	hysici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown		Other (specify)			Month	Day Year
detached	Δ.	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23a. Did tob	acco use contribut	te to the cause of death?
8	d by				,			s 2□No 3□	
plnods	ompleted						24a. Was ar		autopsy findings availat
O O							autops: perform	prior deat	to completion of cause on the cause of the c
age	BeC	25. Was case referred to medical				26. Place of De	Yes 2 ath (Check only one	□ No 1 X	Yes 2∐No
0		examiner? 1 \(\text{Yes} 2 \(\text{No} \)	lospital: 1 🔀 Inpatient 2 🗌	ER/Outpatien	t 3□ DOA Oth	000	lome 5 Reside		Specify)
0	2	27. Manner of Death 1-□Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	k?	28d. Describe ho	w injury occurred	
ral director, p	H .					Yes 2 □No	001 111 (0)		
ral director, p	H .	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		me, tarm, stre	et, factory, office		City or Town	eet and Number of State)	r Rural Route Number,
ral director, p	ertification: T	Z C / TOURGOIN	28e. Place of Injury - At ho building, etc. (Specify	1)					
ral director, p	Certification: T	3 Suicide 4 Homicide 6 Could not be determined	building, etc. (Specify	wledge, death	occurred at the tir	me, date and place	a, and due to the ca	use(s) and manne	r as stated.
ral director, p	Certification: T	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify sician: To the best of my knowner: On the basis of examinal and manner stated.	wledge, death	occurred at the tir restigation, in my o	me, date and place pinion, death occu	e, and due to the ca irred at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
pietely filled in by the funeral director, p	ertification: T	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only) 7 Medical Exami	building, etc. (Specify sician: To the best of my kno- ner: On the basis of examinal	wledge, death	occurred at the tir restigation, in my o	pinion, death occu	erred at the time, da	te and place, and d. Date signed (M	due to the cause(s)
ral director, p	edical Certification: T	3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	building, etc. (Specify sician: To the best of my kno- ner: On the basis of examinal	wledge, death	estigation, in my o	pinion, death occu	erred at the time, da	te and place, and d. Date signed (M	due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPICE Age (In vis. last birthday) ear If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex Funeral Hours Months 1 M 2 □ F Mary 214-50-279 Director Usual Residence of Decedent with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-f show other treumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director more Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes, Give Year or Date. or items 23e Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Year or Dates: Blac 3 ☐ Widowed 4 ☐ Divorced "netural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within . Department of Health and Mental Hygiene. Importent: If item 27 is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) onstruction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (mother) 1102 301 HO. (1) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GreenMount (eny injury o 4 ☐ Donation 75 ☐ Other (Specify) rematory 22. Name and Address of Filty Joseph L. Russ Funeral Home 2222 W. North Ave. Batto. Md. 2121 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Orset and Death se on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by a page 2 should be detact 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Tunknown 1 ☐ Yes 2 ☐ No Be Completed Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 2□ No 1 ☐ Yes 2/ 1 Yes Hospitel or Attending Physicien: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 🗆 Yes 2 ER/Outpatient 3 DOA 5 🗌 Residence 6 Other (Specif 1 Inpatient After this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manne of Death Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL **Physician** 12:03AM 2005 Cozart /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GOOD SAMARITAN HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days 1 ☐ M 200 F 45-48-751 Usual Residence of Decedent Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show ortant: If item 27 is markad other than "natural", or itams 23a or 28a-f shov injury or other traumatic event, the Modical Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director eet and Numbe 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, med Forces?

Yes 2 No
Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 4 Divorced Year or Dates: 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4or 5+) Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, Method of Disposition

Burial 2 Cremation 3 A

Donation 5 Other (Specify) 2 Cremation 3 Removal from State 21. Signature of Funeral Service Licensee -W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ZDAYS **Physician** ISCHEMIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Donknown IDO CARDITIS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an DISEASE autopsy 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifies 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 1 Yes 12 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 🗌 No Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier + 04107105 poleted cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL 30. Name and address of pers

Registrar

State

DHMH 17 Rev 1/2001

BERT

31. Date filed (Month, Day, Year)

BOURJEIL

32. Registrar's Signature ORIGINAL

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OCH RAVEN BLVD, BALTIMORE, MDZ1239

			1 - State Unpend Item Registrar	State of Maryland 23a,27,28a-f per	/ Departm	ent of He 24-28 ate of E	ealth and M 5 95 th ^{‡as}	ental Hy	giene Reg. No.)5	2310
	Physici /Medic		1. Decedent's Name (First, Middle, La	Chook	S			2. Date of De Month	Day	Year	Time of Death
	Examir		4a. Facility Name (If not institution, giv SINAT HOSPITAL	re street and number)			Location of Death ORE CITY	AFRIL	4c. County	of Death	
3/09	Funeral Director	2	17-82-9391	Sex 7. Age (In yrs. last	t birthday) If U Yrs. Mon	ths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da	th y, Year)	9. Birthplace	(State or Foreign
2)	aryland show	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location	-					Inside City Limits
	death with the Maryland ms 23a or 28a-f show Livast be notified at	Director	10e. Street and Number	150		Ore.			10g. Citizen of		1AYes 2□No
	death w	Funeral	2740 Fenu	12. Was Decedent Ever in U.S.	13. Was D	2 2 ecedent of His	panic Origin? (Spe , Mexican, Puerto I	cify Yes or No	US - 14. Rac	ce - American I	ndian,
9200	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. item 27 is marked other than "neturel", or items 23a or 28a-f show other treumetic event, I'm Medical Exercitives: stat by notified at	by	Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	es 2 No	Specify:	чсап, өсс.)	Specif	ck, White, etc.	CC
21215-0036	ithin 72 h ie. ian "netu Medica	Completed	15. Decedent's E (Specify only highest gra Elements (Sepondary (0-12)	ducation 1 ade completed) College (1-4or 5+)	6a. Decedent's (Give kind o lite. DO NO	Usual Occupat f work done du T use retired)	tion uring most of workit	ng	16b. Kind of B	usiness/Indust	ry
	e filed wi al Hygien I other th vent, Ita	Be Con	17. Father's Name (First, Middle, Last)	MC	Liter	2 18. Mother's Name	(First, Middle,	Maiden Suman		vices
Maryland	should b ind Ment s marked umetic e	To	19a. Informant's Name/Rejationship (Type, Print)	19b. Mailing Add	ress Str ar	LOSS nd Number or Rura	Sie	Blog er, City or Town,	State, Zip Coo	de)
	t and 2 Health a tem 27 is		OSSI e Blo 20a. Method of Disposition	ount 20b. Place	274C	Tex (Name of	WICK	Ave	B.J.	to M	021218
Baltimore,	Page ment c ant: If ury or		Y Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special	(y) M	etery, crematory	or other place,	tony 4/	14/05	Balt	> MC)
Bal	permit. Departr Importe any inji		21. Signature of Funeral Service Licer	In Street	Vay	e and Address	Chrie	ne t	alto	Mil 2	1212
	Pnysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	dications that caused the death. If one cause on each line. Narcotic(meth				respiratory ar	rest,	Inte	proximate erval Between set and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequen							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	ce of):						
68760,	riticate be executed og physician and as the burial-transit		resulting in death) Last	Due to (or as a consequen	ce of):						
	certiticate iding phy ise as the	/Medical	IF FEMALE:	23c. If yes, outcome of pregnancy	,						
P.O. Box	To the Hospital or Attending Physicien: The law requires that the death certiticate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 □Ectop	c pregnancy (specify)				te of delivery nth Day	Year
	uires that the dei signed by the a Id be detached t	by	Part II. Other significant conditions of	contributing to death but not resulting	g in the underlyi	ng cause given	in Part I.		bacco use cont		use of death?
Vital Records,	law requir las been s s 2 should	Completed						24a. Was	an 24b. \	Were autopsy 1	indings available
ital R	To the Hospital or Attending Physicien: The lav Within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Be Con	25. Was case referred to medical examiner?				26. Place of Death	1 Yes	med? c 2☐No 1	death? ☐ Yes 2☐	
of V	g Physic er this ce eral dire	၉	1 X Yes 2 □ No 27. Manner of Death		Outpatient 3□	DOA Other: 28c. Injury a Work?	4 Nursing Hom		ence 6 Oth		unk
Division of	ttending F death. ctor: After y the funera	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	4-10-05 mi	Injury In	1 🗆 Ye	as 2 X No				
DIV	pital or /		4 D Homede	residence			Be	altimor	e, Mary	land	awmin Ave.
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	one) 2 XMedicel Exam	ysician: To the best of my knowled niner: On the basis of examination and manner stated.	dge, death occur and/or investiga	tion, in my opir	nion, death occurre	d at the time, o	date and place, a	and due to the	cause(s)
	witi To	~	29b. Signature and title of certifier	King was		29c. License r		4	29d. Date signed APRIL	11, 20	
Ó	Í		30. Name and address of person who	completed cause of death (Item 23	a) (Type, Print)	111 Pe	nn Street	t Balt	imore	Marvlar	nd 21201
97	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 2	32. Registrar's Signature	Span					J 1(1)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Deceden Name (First, Middle, Last 3. Time of Death Month Year **Physician** 5:30 10 2005 TORI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lospita ltimore If Under 1 Year (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Min Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28e-1 show any injury or other traumatic event, it a Machinal Examiner must be nufficed at once. 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Black, White, etc. Marital Status American Indian 1 Never Married 2 Married 1 Yes 2 No Specify: 4 Divorced 3 Widowed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working ITE. DO NOT use retired) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame, 19b. Mailing Address 20a. Method of Disposition 1 □ 8urial 2 □ remation 3 Removal from State ^¹ 4 □ Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee leur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician WWW Cancer /Medical Due to (or a a consequence of): Examiner COUNCE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No detached for Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ישופו been signed by ו page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053641 0 u. completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Michelle Juanoza MP. Sa MD 21237 Dr. Baltimore

State Registrar

Franklin

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32. Registrar's Signature

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1	15	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ate food foor foo?		-			
1			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD L. LINTHICUM, M. D., 76.01 OSLEI 31. Date filed (Month, Day, Year), 2005 32. Fegistrar's Signature.	R DRIVE	, TOWSON	I, MAF	RYLA	4D 218	204
	Sta Registr	1	31. Date filed (Month, Day, Year) 2005 32. registrar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month. Year **Physician** JAMES WILLIE CLARK ,30 PM 12 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner 5 Hospital If Under 24 Hrs. 8. Anne 200 m 6/2/ room 1 If Under 1 Year Date of Birth (Month, Day, Dec 29 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 78 244-32-7053 Director Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or Items 23a or 28e-f show other treumatic event, the Madical Examinar must be notified at Maryland Anne Arundel Glen Burnie 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Ilene Road 21060 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Xes 2 □ No If Yes, Give Year or Dates: WW 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ent: If Item 27 is marked other than "naturelt, or ite 1 Never Married 2 Married 1 ☐ Yes 2 ☐ **X**lo Baltimore, Maryland 21215-0036 ᅙ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dispatcher Colonial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Preston Clark Mary Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Q. Clark (WIFE) 111 Ilene Road, Glen Burnie, Md. 20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ 4/8/2005 permit. Page Department of Importent: If any injury or once. Baltimore, Maryland Cedar Hill Cemeterv * 4 □ Donation 5 □ Other (Specify) Kevin 21. Signature of Euneral Service Licensee Ecker Mccurily-polyntak Funeral Home, 237 E. Patapsco Ave., Balto., Home, 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nehmans Enysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physicien and hed for use as the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a Wasan hes certificate 25 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 7 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28b. Time of Injury 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide ŏ within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the

State Registrar 29b. Signature and title of certifier

KOF 31. Date filed (Menth.

30. Name and address of person who completed cause of death (Item 23a) (Type, P

DHMH 17 Rev 1/2001

ORIGINAL

29c. License number

DHMH 17 Rev 1/2001

Registrar

Marguerite Cook 05-2436 AKG

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 5 23	15
	Physicia		1. Decedent's Name (First, Middle, Last) MARGUERITE A. COOK 2. Date of Death Month Day Yeer April 7, 2005 9:19 A	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	•
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	1 and Healt am 2 thar		EVERETTE COOK/ HUSBAND 308 S. MACON STREET BALTIMORE, No. 21224 20a. Method of Disposition (Name of Date 20c. Location - City or Town, State	-
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Baltimore,	permit. Pag Department Important: I any injury o		21. Signature 1 al Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME	
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3	1		30 Name and address of person who completed cause of death (them 23a) (Type, Print) 10 Sha Z Given bern M.D. 111 Penn Street Baltimore, Maryland 2120)1
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			For State Registrar	State of Marylan	d / Depa		ealth and M	ental Hyg	_	5	12316
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	/Medic Examir		4a. Facility Name (If not institution, give s North Arundel Hos	street and number)		Gler	Location of Death Burnie	1		of Death	ndel
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	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan adminish and Mantail Hygiene adminish Indianation House adminished the file and marked other than "natural", or liems 23e or 28e-f show ortent; it fam 27 is marked other than "natural", or liems 23e or 28e-f show injury or other traumatic event, the Medical Engine must be notified at injury or other traumatic event, the Medical Engine must be notified at each of the property of the months of the	by Funeral Director		12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	i i		spanic Origin? (Spe n, Mexican, Puerto	ocify Yes or No- Rican, etc.)		e - Americ k, White,	
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K P	quires that n signed b uld be deta	ed by PI	Part II. Other significant conditions con	tributing to death but not resu	on in Part I.	23e. Did tobacco use contribute to the cause of death					
Jaki at the ME/IK Ivision of Vital Record	The la ate has page 2	Completed by	Renal Failu	ul				24a. Was an autopsy findings a prior to completion of ca death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No			npletion of cause of
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dav Year **Physician** Michael Owen Connaughton April 9 2005 /Medical 8:10 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2979 Friends Road Anne Arundel Annapolis
If Under 24 Hrs. 8, [If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours Yrs. 214-42-7138 Director 62 April 3,1943 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Meryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural; or items 23s or 28s-f show Lry or other traumetic event, I'm Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXNo Funeral Director Anne Arundel Annapolis MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2979 Friends Road 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White Specify: ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Attorney Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Owen Harrison Connaughton Dorothy Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Timms Connaughton (Wife) 2979 Friends Road, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/12 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or Baltimore, MD 2005 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 Enter the disea or heart failure , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Physician Levheung 119 /Medical Imr edi de Cause (F disea a or condition res ang in death) **Examiner** Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use es the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 21 NO 1 ☐ Yes 2 ☐ No 1 TYes Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifice completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 9838 111/2005 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Besigate Rd. Annapolis, Und. selouicu, 900 aut . Wo 32 Registrer's Signature 31. Date filed (Month, Day, Year) APR 1 2 2005 State Registrar

			1 - For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygie		12318		
}	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Last, ROBERT 4a. Facility Name (If not institution, give THE JOHNS HOPKINS	street and number)	CLARK 4b. City, Town, or Location of Deat BALTIMORE	2. Date of Death Month	Day Year 10 2 005 4c. County of Dea	5 1.30 PM		
	Funeral Director		5. Social Security Number 6. Second 147-20-9649 Usual Residence of Decedent	7. Age (In yrs. last birthday M 2□ F 77 Yrs.	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth Month, Day, You March 29	9. Bir , 1928 Ne	rthplace (State or Foreign ountry) EW Jersey		
	ith the Maryland or 28a-f chow	Director	10a. State 10b. County Maryland Prince G 10e. Street and Number		10f. Zip Code		. Citizen of What Co	•		
920	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f ehow idical Examinar must be notified at	by Funeral Director	7310 Split Rail L 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced		20707 . Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:		14. Race - Ame Black, Whit	erican Indian,		
21215-0036	filed within 72 ho Hygiene. Ither than "natur. Int, the Modical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th Grade	College (1-40f 5+)	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) Line Mechanic	Sb. Kind of Business/Industry Aviation				
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Baltimore, M	f and fealth om 27 her tr		Michael R. Clark 20a. Method of Disposition 1 Burial 2 Cremation 3 B 4 Donation 5 Other (Specify)	emoval from State 20b. Place of Disp cemetery, cre	Split Rail Lane. position (Name of penatory or other place) ash. Crematory 04	Date 200	. Location - City or			
■ Balti	permit. Pages : Department of H Importent: If ite any injury or ot		21. Signature of Euneral Service License	M00869	22. Name and Address of Facility F. 7601 Sandy Spring	leck Funer Road, Lau	al Home, rel, MD.	Inc. 20707		
	rate be executed /Medical kysician and the burial-transit the burial-transit transit t	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Cations that caused the death. Do not en le caused in each line. IMETASTATIC PRODUCTION Due to (or as a consequence of): BLADDER CANCOUNT Due to (or as a consequence of): BACTOREMIA Due to (or as a consequence of):	STATE CANCER	y or respiratory arrest,		Approximate Interval Between Onset and Death 3 years 20 years 2 days		
P.O. Box 68	Attending Physiclen: The law requires that the death certificate be executed refeath. refeath. settor: Atten this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year			
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DIVI	Hospitel or At 4 hours after d Funerel Diract ely filled in by	<u>a</u>	4 ☐ Homicide determined 29a. Certifier 1 ☑ Certifying Phys	289. Place of Injury: At nome, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route City or Town, State)						
)		Medical	(Check only 2 Medical Examin 29b. Signature and title of certifier Wirm 2000 30. Name and address of person who cor NIRUPAMA MITIKIS 31. Date filed (Month, Day, Year) APR 1 2 200	and manner stated.	29c. License number	29d. 1	Date signed (Month	1. Day, Year)		
	4	-	30. Name and address of person who cor NIRUPAMA MITIKIE 31. Date filed (Month Day Yoar)	mpleted cause of death (Item 23a) (Type,	Print) Hospital, 600 N. Wo	lfe Street,	Baltimor	re MD 21213		
	Sta Registr	e ar	APR 1 2 200	32. In gistrar's Signature	parle					

			For	State of M	aryland /		artment of H		lental H	ygien	Z. UUJ	12010
			Ragistra MEND TTEM 1. Decedent's Name (First, Middle, Las	4c PER P	IY C842	4/1	tificate of l	Jean	2. Date of D	Reg. No	D	3. Time of Death
	/sicia ledic	al SUSAN MARIE CASMIRE								11L 9 2005 1910M		
Ex	amine	er	4a. Facility Name (If not institution, give	street and number	Lasata	/	4b. City, Town, or	Location of Death	1. /=	40	County of Death	UNDEL
Fun	aral		5. Social Security Number 6. Se	x 7. A	ge (In yrs. last b	inthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of E	irth	9. Birthp	lace (State or Foreign
Dire			305-72-2440	⊐м 2 Х 1 F	41	Yrs.	Months Days	Hours Min.	8. Date of E (Month, I 06/29/) ay, Year) 1963) Coun	in IN
pur	S.F.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Toy	von or Le	cation					Del Incide City I I I
Manyla f sho	18 T B	5	MD ANNE ARU	NDET.	MILLER						"	0d. Inside City Limits 1 ☐ Yes 2√ No
tha!	1	Director	10e. Street and Number	TIDEE	TITELLI		10f. Zîp Code	•		10a. Cît	tizen of What Coun	
h with	21 12	<u>a</u>	8200 HORTONIA POI	NT DRIVE			21108				USA	•
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Importent: If item 27 is marked other then "naturel" or Itams 23e or 28e-f show	Zandracini	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed ★★★ Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2X1 If Yes, Give Year or Dates:	?		Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes ※XXNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	lo-	14. Race - America Black, White, e Specify: WHI	etc.
21215-0036 d within 72 hours aff giene. arthen "naturel", or	4	ted	15. Decedent's Edi	ucation	16a	. Dece	lent's Usual Occupa	ation		16b. K	(ind of Business/Ind	lustry
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anc dbe fi ntal H ed ot	949	m	17. Father's Name (First, Middle, Last)	min.				18. Mother's Nam			Surname)	
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Te, Ma 1 and 2 st Health ar 1 em 27 is	ir tre	1		MOTHER							RSVILLE,	
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Baltimo	any inj		21. Signature of Funeral Service Licens	COOKLY	M01415	1	Name and Addres	s of Facility SIN VE. SW, (NGLETON GLEN BU	FUN RNIE	ERAL HOME , MD 210	
	4.		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause ne cause on each I	d the death. Do	not ent	er the mode of dying	, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Physic			Immediate Cause (Final disease or condition resulting in death)	ENO	STAG		CONGE	JUVE	HEARC	(-	ALLUKE	Onset and Death
/Medi Exami			resulting in death)	Due to (or as	a consequence	of):						
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penn. p	ansii.	Examiner	rans, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			ŕ						
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J.O. BOX 6 at the death certifi by the attending	an ioi na	Pnysician/me	23b. Was decedent pregnant in the past 12 gronths? 1 Yes 2 No 9 Unknown 2								23d. Date of delivery Month Day Year	
r g	a della	by Pr	Part II. Other significant conditions co	ntributing to death b	out not resulting i	n the u	derlying cause give	n in Part I.	23e. Did	tobacco u	use contribute to the	cause of death?
Cords w require baen sig									1 🗆	Yes 2	No 3 □ Proba	bly 4 □Unknown
Hecords, he law requires t a has baen signe	otte 7	Completed							24a. Wa		24b. Were autop	sy findings available
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this this	<u> </u>	0	1 ☐ Yes 2 No 27. Manner of Death	lospital: 1 X npation 28a. Date of Inju		-		4 Nursing Ho			6 ☐Other (Specify)	
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DIVISION of or Attending after death. Director: After	om K	ermication	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	ury - At home, fa	arm, str	eet, factory, office		28f. Location	Street an	d Number or Rural	Route Number,
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To the Hospitel or within 24 hours af To the Funeral D		edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best ner: On the basis o and manner st	of my knowledge of examination areas	e, death	occurred at the time estigation, in my op	e, date and place, inion, death occurr	and due to the ed at the time	cause(s) date and	and manner as sta I place, and due to	ited. the cause(s)
To the To the		5	29b. Signature and title of certifier 10 10 10 10 10 10 10 10 10 10 10 10 10 1	h			29c. License	0824		29d. Dat	esigned (Month, D	ay, Year)
2			30. Name and address of person Wio co	impleted cause of c	leath (Item 23a)	(Туре,	Print)	I ILAGO	mn i	-1-	NI RIIDA	IIF MD
)						त	HKUNUE	-L MUSY	المحر ال	THE	10 040	
	State	9	31. Date filed (Month, Day, Year)	32. Hagistr	ar's Signature	-						
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SUSAN M. CASMIRE

ORIGINAL

State of Maryland / Department of Health and Mental Hygier (2) 15 1- State Registra amend item #10a-f &17 PER INC 618#3afs 12.05at HH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year Mary Ам Cowne S. 10, 2005 /Medical April 8:10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Citizens <u>Nursing Home</u> Frederick Frederick
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1□M 2□F Months Hours 93 Yrs. Director 578-32**-**3335 Oct 19, 1911 Virginia Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 7 is marked othar than "natural", or itams 23e or 28a-f show treumetic event, the Medical Examiter must be modified at FREDERICK Director 1 Yes 2 No NC MD Iredell Stony Point FREDERICK 10e. Street and Number 1900 ROSEMONT AVE. 10f. Zip Code 10g. Citizen of What Country? with 21702 28678 Funeral U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked othar than "natural", or ita Black, White, etc. 1 □ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify Specify: White 3 ☑ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government 12 Accounting Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Shanholt SHANHOLTZ Martha Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Cowne-- Son 313 River Cliff Dr Stony Point NC 28678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 5 Ft. Lincoln Cemetery 4/13/05 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home permit.
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Imports
any nju 21. Signature of Funeral Service Lice Spe 3401 Bladensburg Road Brentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Advanced Dementia With Failure to Thrive Months /Medical Due to (or as a consequence of) Examiner Hypertension Months: Sequentially list conditions, if any, beauting to inminociate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence ory Examiner -transit Atrial Fibrillation Years and Due to (or as a consequence of): burial-1 P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) ☐Yes 2 X No detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Hypercholesteremia 1 ☐ Yes 2 ☑ No 3 ☐ Probably Completed 4 Unknown Anemia, Osteoporosis, Depression 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Vit B12 Deficiency, Dysphagia Division of Vital 212 No 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ▼ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 X Natural 5 Pending thours after death.

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2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54749 April 11, 2005 30. Name and address of person who completed cause of ath (Item 23a) (Type, Print) Allen Reilly MD 7/011 801 Frederick, MD 21701 House Ave D-1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

GERARD CHASE 05-02285 RKD

			1 - For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death		ene 2005 232	
	Physic /Med		1. Decedent's Name (First, Middle, Las GERARD CHA	SE		2. Date of Death Month MARCH	3. Time of Death 3:05P. M	
1	Exami		4a. Facility Name (If not institution, give UNIVERSITY SHOCK	TRAUMA UNIT	4b. City, Town, or Location of De BALTIMORE		4c. County of Death	
	Funeral Director		5. Social Security Number 215 · 11 · 1744 Usual Residence of Decedent	7. Age (In yrs. last birthda		Irs. 8. Date of Birth in. 05 25	9! Birthplace (State or Foreign Country) MD	
	r 28a-f ahow	tor	10a. State 10b. County	10c. City, Town or BALTIM			10d. Inside City Limits 1 ★Yes 2 □ No	
	ath with the 23a or 28a unt be noti	Il Director	10e. Street and Number 4311 MARBLE	HALL RD	10f. Zip Code	10g	p. Citizen of What Country?	
036	s after des or Itema	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Ammed Forces? 1	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
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	as 1 and 2 shoot Health and itam 27 ian		19a. Informant's Name/Relationship (7 EUGENE V. CH 20a. Method of Disposition	ASE SR. 431 20b. Place of Dis	iling Address (Street and Number or MARBLE HA	Ц RD	BALTO. MD 21218	
Baltimore,	Z = E 2		1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)	Removal from State	HILL 04.		c. Location - City or Town, State SALTO . MD	
Ba	permit. P Departm Importar any inju	N.	21. Signature of Funeral Service Licens	II Y	22. Name and Address of Facility AUGHN C. GREENE 151 BALTO, NATL' P	IKE BALTO	. MO 21224	
	Enysician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. Do not enter the cause on each line. a	nds (a) of	ac or respiratory arrest	, Approximate Interval Between Onset and Death	
68760,	icate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
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	w requires that been signed I should be det	b	Part II. Other significant conditions co	ntributing to death but not resulting in the	23e. Did tobac	Did tobacco use contribute to the cause of death? ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown		
Vital Records,	The ate ha	e Completed	25. Was case referred to medical			24a. Was an autopsy performed 1 X yes 2 =		
of	ding Phys .r After this funeral di	Certification; To Bo	examiner? **Times**	e 6 □Other (Specify) njury occurred + SNo+				
Div	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director:		4 Homicide determined 29a. Certifier 1 Certifying Phy	28e. Place of Injury - At home, farm, si building, etc. (Specify) Countries: To the best of my knowledge, dea	th accurred at the time, date and place	City Town, S	nerce street	
	To the Fu within 24 To the Fu completei	Medical	(Check only 2 Medical Exami	ner: On the basis of examination and/or in and manner stated.	29c. License number OCME	curred at the time, date	and place, and due to the cause(s) Date signed (Month, Day, Year)	
4			PATRICIA Aron	empleted cause of death (Item 23a) (Type	, Print)		RIL 1,2005 re, Maryland 21201	
ý	Sta Registr		31. Date filed (Month, Day, Year) APR 12	2005 32. Registrar's Signature	gare			

			For State Registrar	State of Maryland	/ Department of Certificate of		Mental Hygien	6005	12322			
	Physici /Modic		1. Decedent's Name (First, Middle, Last) ANNA CARDE	ray			2. Date of Death	ay Year	3. Time of Death			
	/Medic Examin		4a. Facility Name (If not institution, give s Chapel Hill Nors A		4b. City, Town,	or Location of Death		c County of Death				
	Funeral Director		26 20 - 00 [1]	M 26 F 7. Age (In yrs. last	t birthday) If Under 1 Yea Months Days		8. Date of Birth (Month, Day, Yea)		ace (State or Foreign			
	Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County RAT	10c. City, T	own or Location			10	Od. Inside City Limits			
	with the had a or 28a-	Funeral Director	10e. Street and Number Mikmo	At RD	10f. Zip Code	7.07	_	Citizen of What Coun	try?			
36	be filed within 72 hours after death with the Maryland Ital Hygiene. of other then "naturel", or Items 23e or 28e-f show event, ite Medical Extrallighters the rediffed at	y Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No-	14. Race - America Black, White, 6 Specify:				
21215-0036	within 72 hou noe. I han "nature In Medical	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 1 completed) College (1-4or 5+)	6a. Decedent's Usual Occu (Give kind of work don life. DO NOT use retir	e during most of work	king 16b.	Kind of Business/Ind	ustry			
	be filed Ital Hygi Id other event, t	To Be Co	17. Father's Name (First, Middle, Last) William Ha	IArci	DAIA CN		e (First, Middle, Maide	en Sumame)	U			
Maryland	2 sho and l is ma	_	19a. Informant's Name/Relationship (Type Stephenic D)	Roma Doyaler	9b. Mailing Address (Stree	et and Number or Ru	ral Rout Number, City	or Town, State, Zip	Code) 207			
Baltimore,	Pages 1 and nent of Heatth int: If item 27 iry or other to		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donalon 5 Other (Specify)	emoval from State	e of Disposition (Name of etery, crematory or other plants	ace)		Location - City or To	wn, State			
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License		22, Name and Add		51.51	BALT! No	111:4			
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each ine.	814 LUNG.				Approximate Interval Between Onset and Death			
	Examiner	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequent								
0,	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Classass or injury	C Due to (or as a consequence of):								
c 68760,	ntificate bing physic	Medical	IF FEMALE:	d:								
P.O. Box	Attending Physicien: The law requires that the death certificate be executed rideath. etc. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the buriat-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3 Ectopic pregnant	су		23d. Date of deliver Month	y Day Year			
	w requires that been signed b should be deta	þ	Part II. Other significant conditions conf	ributing to death but not resultin	ng in the underlying cause g	iven in Part I.		use contribute to the				
Division of Vital Records,	t: The law re icate has be r. page 2 sho	Completed					24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ N	prior to com death?	sy findings available pletion of cause of			
Ĭ.	sicient certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ ER	(Outpatient 35 DOA 0		h (Check only one)	a = 0.15				
ion of	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	atlon: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		b. Time of 28c. Injury Wo	ury at ork? ⊇ Yes 2 □ No	ome 5 Residence 28d. Describe how inju					
Divis	el or Atters s after des la Director di n by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28f. Location (Street a City or Town, Star		Route Number,						
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical C	29a. Certifier 1 → Certifying Physic (Check only one) 2 → Medical Examin	cian: To the best of my knowleder: On the basis of examination and manner stated.	dge, death occurred at the tand/or investigation, in my	time, date and place, opinion, death occur	and due to the cause(s red at the time, date an	s) and manner as stand place, and due to	ted. the cause(s)			
	Tott within Tott	Σ	29b. Signature and title of certifier	C.S. RAO. T. S		3462		ate signed (Month, D				
	12		30. Name and address of person who cor	npleted cause of death (Item 23	a) (Type, Print) 1C S	RACITO.	0.	21133				
	Sta Registr	te ar	31. Date filed (Month, Day, Year) APR 12 20	32 Registrar's Signatur	Sparke							

			1- State of Maryland / Department of Health and N Certificate of Death		ene 005	12323					
	Physici /Medic		1. Decedent's Name (First, Middle, Last) EOMUND K. COBBS	2. Oate of Death 04. 02.	2005 ear	3. Time of Death 4:50 AM					
	Examir		4a. Facility Name (If not institution, give street and number) 1502 KING WILLAM WAY 4b. City, Town, or Location of Death CAIDNSVILLE		4c. County of Dea	ath 1006					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 4 Months Days Hours Min.	8. Date of Birth		rthplace (State or Foreign ountry)					
	yland now		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
	he Mar 28a-1 sh	ector	MD BALTIMORE CATONSVILLE			1 ☐ Yes 2 No					
	h with t	Funeral Director	1502 KING WILLIAM WAY 21228	10	g. Citizen of What C	ountry?					
	ter deal	uner	11 Marital Status 12 Was Doodfort Ever in U.S. 12 Was Doodfort of Vicencia Original (Sa	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi						
21215-0036	ours af	by	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 New Year or Dates:		Specify: B	LACK					
15-(in 72 h n "natu Vedica	Completed	15. Decedent's Education (Specify only highest grade completed) [Secondary (2010)] 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT user attired)	ing 16	6b. Kind of Business	/Industry					
212	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-1 show ent, the Medical Ever it writings be rediffed at		12 1H GRADE 4 VRS ADMINISTRATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name	3		F MD.					
Maryland	uld be filed Mental Hygi arkad other atic event, I	To Be	EDWARD 3. COBBS GLADYS	e (First, Middle, Ma HEAT	uden Sumame) H						
Mary	2 sho and ls ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		City or Town, State,	Zip Code)					
_	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition 20b. Place of Disposition (Name of		oc. Location - City or	Town, State					
altimore,	On = + 0		4 Donation 5 Other (Specify) ARBUTUS 04.0	8·05 B		MD					
Ba	permit. Pa Departmer Important any injury once.	N I	21. Signative of Funeral Service Licensee VAUGHN C. GREEN 5151 BALTO. NATT	E FUNE	RAL SER	MD 21229					
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac cannot, or head-ailure. List only one cause on each line.	or respiratory arres	, ,	Approximate Interval Between					
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. GASTRIC CANCER Due to (or as a consequence of):			Onset and Death					
ı	Examiner	L									
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause.								
60,	icate be executed physician and s the burial-transit		Due to (or as a consequence of):								
09/89	E 00 6	edical									
ROX		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1		23d. Date of de	livery Day Year					
o.	The law requires that the death cer the has been signed by the attendir page 2 should be detached for use	hysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								
JS, F	ires tha signed t be det	p	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			o the cause of death?					
Hecords	sw requires been significant to the state of	Completed		24a. Was an		utopsy findings available					
		Com		autopsy performe 1 Tes 2	nrior to	completion of cause of					
VItal	Phyaician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Check on one		oib.)					
n or		on: I	27. Manner of Death 28a. Date of Injury 1 ☑Natural 5 □ Pending 28a. Date of Injury 28b. Time of 28c. Injury at Injury Work?	28d. Describe how		City)					
UIVISION	deat ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stree	et and Number or Ri	ural Route Number,					
5	e Hospital or Al 24 hours after o Euneral Dirac etely filled in by	Cert	building, etc. (Specify)	City or Town, .	,						
	To the Hospital or twithin 24 hours after To the Funeral Dirac completely filled in b	ledical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and place, and manner stated.	and due to the caused at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)					
	To th Withir To th	Me	29b. Signature and title of certifier 29c. License number D16619		Date signed (Mont						
	4				raich S,						
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. VERGARA—SDARES 9940 FRANKLIN SQUARE DR. 31. Date filed (Month, Day, Year) 2005 32 Registrar's Signature	BALTIMO	DRE, MD.	21236					
•	Sta Registr	ie . ar	APR 12 2005 Same Signature								

7.7	-		For State Registrar		State of M	1arylan			nt of H <i>te of L</i>			lental H	ygien Reg. N	UUU.	12324
	Physici	ian	1. Decedent's Name () Disharoc	'n		•				2. Date of D Month	eath	ay Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If n					4b. City	, Town, or	Location	of Death	APRIL	6	, 2005 c. County of Death	2122 1
				SQUARE HOSPITAL ROSEDALF						If I Indo	or 24 Hrs	0. D		ALTIMORE	
ı	Funeral Director		5. Social Security Nur 215-32-2		M 2□MF 7. A	Yrs.				8. Date of B Month, D Feb.	ay Year	935 Mar	place (State or Foreign ntry) 1and		
	land ow		Usual Residence of D	Decedent 10b. County		10c. Cit	y, Town or Lo	cation						1	10d. Inside City Limits
	e Mary 3a-f sh tiffed	Director		Baltimo	ore		Esse	X							1 ☐ Yes 2 XNo
	th with th	ai Dire	10e. Street and Numb		Ave.				ip Code 21221	1			10g. C US	itizen of What Cour A	ıtry?
336	hours after death with the Maryland tural, or Items 23a or 28a-1 show al Exertifier with be netitled at	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4		12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	?] No	1	Was Dec If Yes, sp 1 Yes		spanic O n, Mexica Specify		ecify Yes or N Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Whi	etc.
215-0036	within 72 hours ene. than "natural", nu M. Jical Ex	Completed	(Specify	5. Decedent's Ed y only highest grad dary (0-12)	ucation de completed) College (1-4or	5+)	(Give kind of work done during most of working life. DO NOT use retired)						Kind of Business/Ind	•	
Z D	be filed w tal Hygien d other th		12th 17. Father's Name (F)	irst, Middle, Last)			Home	maĸ	er	18. Moth	ner's Name	(First, Middle		wn home	
/land	ed la be	To Be	Harry							El	izak	oeth D	ies	el	
Mar	and and surr		19a. Informant's Nam Hubert D			and		9	•					or Town, State, Zip	
	of Health of Health fitem 27 r othar tr		20a. Method of Dispo-	sition	Removal from State	20b. P	Place of Dispo	sition (Na	me of other place	e)	С	ate	20c. L	ocation - City or To	own, State
altimore,	t. Pag rtment rtant: i		'4 □Donation 5	Other (Specify)	0a	kLawn		etery		4/9/			ltimore	
g	Depa Impo any Ir		21. Signature of Pulle	en	Com	ell	u "				Co			neralHo e MD 21	meofEssex
			23a. Part1. Enter the shock, or heart Immediate Cause (Fi	failure. List enty o	cations that cause ne cause on each	od the dead line.	•	er the mo	de of dying	, such a	s cardiac o	r respiratory	arrest,		Approximate Interval Between
	Physician /Medical		disease or condition resulting in death)		a. Due o (or a	ensiver a consequence	uence of):	SOSC	leso	nc (asch	ovascu	der	disease	,
	Examiner	er	Sequentially list cond if any, leading to imm cause. Enter Underly	ditions, nediate	b. Due to (or a:	s a consequ	uence of):								
	and transit	Examiner	cause. Enter Underly Cause (Disease or inj that initiated events resulting in death) La:	Jury	c										
58/60,	flicate be executed g physician and as the burial-transit	edicai Ex			Due to (or a	s a consequ	uerice or):								
_		Medi	IF FEMALE:		022 16										
.O. BOX	w requires that the death certif been signed by the attending should be delached for use a	Physician/M	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown	2 months? 4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery Month Day Year				
ds, r	uires that signed b	by	Part II. Other significa	ant conditions co	entributing to death	but not resi	ulting in the ur	nderlying	cause give	n in Part	I.			use contribute to th	ne cause of death?
necords,	The law requires that the the has been signed by the bage 2 should be detached.	Completed										24a. Was auto	opsy ormed?	prior to cor death?	psy findings available impletion of cause of
VIII	ian: T	Be Co	25. Was case referred examiner?	d to medical						26. Plac	e of Death	(Check only		Yes	2 No
> 5	Physic this ce	ု	1 Yes 2 No	0	Hospital: 1 ☐ Inpat 28a. Date of Inj		ER/Outpatient			4 14				6 ☐Other (Specify	/)
	ath. r: After ie fune	atlon	- 4	5 Pending investigation	(Month, D.	ay Year)	Injury	м	28c. Injury Work′ 1 □ Y	a\ 'es 2 □		.bg. Describe	now inju	ow injury occurred	
200	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								l Route Number,				
	e Hospi 24 hou etely fill	edical				of examinat								and manner as st d place, and due to	
	To th within To th compl	Me	29b. Signature and titl	le of certifier			100	29	c. License	number			29d. Da	ate signed (Month, I	
ç	1/	2	Hatr	W	Lonica	-16	lle	Point)	∞	ME			APR]	L 7, 20	05
L	17		30. Name and address	A ACT	DICAG	HAL F	enn St	reet	Balt	imor	e, Ma	aryland	1 212	201	
	Sta Registr	1.0	31. Date filed (Month,	APR 12	2005 32. Regist	rar's Signa	ture /	Joan	of the same						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Kathleen Dillv 8 April 2005 10:50P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9540 Muirkirk Road Apt. Laurel Prince George 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day Year)
Dec. 22, 1950 Shirthplace (State of Country)
California **Funeral** 9. Birthplace (State or Foreign Months 1□M 2\ F Director 213-58-6086 54 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumatic event, the Medical Examinar in usit be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9540 Muirkirk Road Apt. T1 20708 **USA** by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is marked other then "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify:White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bill Collections Collection Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David A. Walton 2 Maureen Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 Is
any injury or other treu Danny Dilly, Husband 9540 Muirkirk Road Apt T1 Laurel, Maryland 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 04/11/05 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Idensee
Thomas Gregor ^{22. Name and Address of Facility}
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cerebral Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner g physician and as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed P.O. Box 68760, alexe IF FEMALE: nse s 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ inne 1 ☐ Yes 2 ☐ No filled in by the funeral director, page 2 should Be Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? Yes 2. No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗍 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 234860 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oleg B. Shpak, M.D. 9470 Annapólis Rd. Lanham, Maryland 20706-3019 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Blave It Sports

ORIGINAL

			1 - For State Ragistrace	Tures !		f Mary	land / Dep	artment <i>rtiticate</i>			Mental	Hygier	LUU.	15	12326
	Physic	an	 Decedent's Name (First, 		st)	00	42 4/1)/	U) JH			2. Date Mont	of Death	Day	Year	3. Time of Death
	/Medi	cal	Anna	М.	Dali						Apri	16,	2005		3:20 a™
1	Examir	er	4a. Facility Name (If not ins Mariner Ho			ŕ			own, or .tim	Location of Dea	ath		4c. County		
	Funeral		5. Social Sepurity Number	6. S	ex		yrs. last birthday,	If Under 1		If Under 24 Hr Hours Mir	s. 8. Date	of Birth		9. Birthp	place (State or Foreign
	Director		182- 16 -5653		□ M 2 □ X F		B3 Yrs.	Mortus	Days	Hours Mil	Februa	h, Day Ye,	1922	Peñn	Šýlvania
	yland iow		Usual Residence of Deceder 10a. State 10b. C		-	100	: City, Town or L	ocation						1	Od. Inside City Limits
	the Marylar 28a-f show	ctor	MD E	Baltin	nore		Towso	П							1 ☐ Yes 🎾 No
	or 28	Dire	10e. Street and Number					10f. Zip (Citizen of V		ntry?
	eath w	Funeral Director	1 Skidmore	e Cour	12. Was Deci	adont Cuar	in II C 10		120		0-11-11		U.S.A		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Heatth and Mental Hygiene. If itam 27 is marked othar than "natural", or Itams 23a or 28a-f show or othar traumatic avant, the Madical Examinating to indiffer a	by	11. Marital Status 1 Never Married 25 3 Widowed 4 Div	•	Armed For 1 Tyes If Yes, Give Year or D	rces? 2 No		was Decede If Yes, specif	y Cubar	spanic Origin? (n, Mexican, Pue Specify:	irto Rican, etc	or No- c.)	Blac	k, White, White,	
5-0	72 ho	Completed	15. De	cedent's Ed	lucation de completed)			dent's Usual		tion uring most of w	orkina	16b.	Kind of Bu	siness/In	dustry
121	vithin ne.	mple	Elementary/Secondary (0		College (1		life.	DO NOT use	retired)	uning most of wi	biking				
d 2	filed v Hygie thar t	ပိ	12 17. Father's Name (First, M	iddle. Last)	п/:	3	Hom	emaker		18. Mother's Na	ame (First M	iddle Maid	Own I		
lan	uld be lental rked c	To Be	Michael		Mur	0				Bertha				∽ maie:	2
Maryland	2 shou and N is mai	 	19a. Informant's Name/Rel	ationship (Туре, Print)		19b. Maili	ng Address (Street a	nd Number or F		lumber, City	y or Town,	State, Zip	Code)
Σ,	and 2 lealth m 27 I		Daniel P. Da	alina.	-husband					t., Tows		D 21:	204		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", any injury or other traumatic avent, the Mcdical Exagnee.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremi	ation 3 🗆	Removal from	State	Ob. Place of Dispo cemetery, cre	matory or oth	er place	· 1	Date		Location -		wn, State
Hin	artmer artmer ortant injury		' 4 □ Donation 5 ☑ Ott	her (Specify ervice Ligen	/ Entombr	ent D				andens 4/ s of Facility R			onium,		Г
Ba	permi Depa Impo any ir once.		Vallet.		ooc WIIIIE	iii u. D				d., Towso			ierar u	uie, .	ис.
8760,	/Medical Examiner bhysician and sthe burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	b. Due to O	eh as a cor or as a cor or as a cor	ps-luence of): sequence of): Meu + sequence of):	tro	n n						Onset and Death
9	ertifica ling ph e as th	Med	IF FEMALE:												
P.O. Box	The law requires that the death certific tite has been signed by the attending p bage 2 should be detached for use as I	Physician/Me	23b. Was decedent pregna in the past 12 months' 1 ☐ Yes 2 No 9 ☐ Unknown	111		inth 2 □ i ant at time	Fetal death 3	Ectopic pred Other (spec					23d. Date Mon		ry Day Year
ecords, P	w requires that been signed E should be deta	by	Part II. Other significant co	nditions co	ontributing to de	eath but not	resulting in the u	nderlying cau	se givei	n in Part I.		Did tobacco	\mathbf{x}	bute to th	e cause of death?
α		Completed									1 3	Was an autopsy performed?	/ pr	/ere autor rior to con eath? Yes	osy findings available inpletion of cause of
Vital	Phyaician: Th this certificate al director, pag	Be	25. Was case referred to m examiner?	-	Hospital				-	26. Place of De	ath (Check o	nlv one)			
of	Phys this ral di	1.	1 Yes 2 No		Hospital: 1 🔲 I		2 ER/Outpatier 28b. Time o		Other : Injury	Marsing I	Home 5 1		6 Other)
ion	Attanding Ph ir death. actor: After th by the tuneral	tion	1 atural 5 P	ending	(Mont	h, Day Yea	r) Injury	м 200	Work?	es 2 No	280. Desci	ibe flow in	ury occurre	iu	
Division	al or Attandi s after death. Il Diractor: A id in by the fu	Certification:	3 Suicide 6 C 4 Homicide	could not be etermined	28e. Place buildir	ng, etc. (Sp					City o	Town, Sta	te)		Route Number,
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 el (Check only 2 Me	rtifying Phy dical Exam	ysician: To the liner: On the ba and mann	best of my sis of examer stated.	knowledge, death	occurred at estigation, in	the time i my opi	e, date and place nion, death occ	e, and due to urred at the ti	the cause(me, date a	s) and man	ner as stand due to	ated. the cause(s)
	To To To I	2	29b. Signatur, and title of c	ertifier - M	0		knowledge, death inination and/or in themp23a) (Type, ignature	29c. l	icense	2539	1	29d. D	ate signed	(Month, E - 2 €	oay, Year)
4) (30. Name and address of pe	erson who	omposted caus	e of death	STUR.	Print) B	al	Finor	e	mp	2	123	39
	Sta Registr	ar	31. Date filed (Month, Day,	Year)	32. R	egistrar's S	ignature	y do		j					
DH	MH 17 Rev 1/20	01		MEN	T W LOC	and the same		Sa							

ORIGINAL

			For State Registrar	State of Ma	ryland		tment of F		nd Me		giene Reg. No.	05	12327
			1. Decedent's Name (First, Middle,	Last)					2.	. Date of De	ath		3. Time of Death
	Physici		William	Davi	ς				A	month Dril	08	2005	10:55 A ^M
	/Medio Examir		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of [$\overline{}$	County of Death	
п			Chesapeake Hos	spice House			Lint	thicum			A	nne Aru	ındel
	Funeral			6. Sex 7. Age	(In yrs. la		If Under 1 Year Months Days		Hrs. 8.	Date of Birt (Month, Da	h y, Year)	9. Birth	place (State or Foreign intry)
	Director		219-07-9256	1XDM 2□ F 8	2	Yrs.				1/25/1	923	1	yĺand
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Loca	tion						10d, Inside City Limits
	sho sho	5	MD Anne Ar	rundel	, ,	adena							1 ☐ Yes 2 ☐ No
	the N	ect	10e. Street and Number	under	- 1 4 5	uucnu	10f. Zip Code				10- 08-	en of What Cou	
	a or	늡						100				en or what cot	into y :
	eath	era	2237 Melvin Dri	12. Was Decedent E	verin U.S.	13 Wa		122 Hispanic Origin	n? (Specif	v Yes or No	USA	4. Race - Amer	ican Indian
	fler d	Funeral Director	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?		lf Y	as Decedent of H es, specify Cuba	an, Mexican, F	Puerto Rio	can, etc.)		Black, White	
8	urs a	b	3√ Widowed 4 □ Divorced	nd 1y∏Yes 2 ☐ N If Yes, Give Year or Dates:		10	Yes 2 No	Specify:				Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23s or 28s-f show Its Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest			16a. Deceder	nt's Usual Occup nd of work done	ation	t undina		16b. Kin	nd of Business/I	ndustry
21	Be. "re	nple	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DC	NOT use retired	d) most o	n working				
2	filed wi Hygien other th	Con	8			Steamf	itter					ern Ele	ctric
nd	be fill d off	Be	17. Father's Name (First, Middle, L	ast)				18. Mother's	s Name (F	First, Middle,	Maiden S	Sumame)	
V a	should Ind Men	2	Albert Davis						s Roa				
Maryland	2 sh and is m		19a. Informant's Name/Relationsh	ip (Type, Print)			Address (Street						p Code)
	1 and Health am 27 ther tr		Albert Davis			223/ Millice of Disposit	elvin Dr	rive, P	asad ^o Date	ena, M		122 ation - City or T	our State
Ö	Pages nent of h int: if ite		1 Burial 2X Cremation		cer	metery, crema	tory or other plac	.		T (200. 200	ation - City of 1	OWII, State
Baltimore,	it. Pa rtmer rtant njury		' 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Services)		Met	ro Crei	natory Name and Addre		9/05		Balt	imore,	MD
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Menial Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at ance.		21. Signature of Funeral Service 2	11/1/1/1/		19			Stal	lings	Fune	ral Hom 21122	e, P.A.
			23a. Parti. Enter the disease, or o	complications that caused	the death	Do not enter		cain_Rd	Pa	saděna _{espiratory} ar	, MD	21122	Approximate
В	22		23a. Party. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final	ply one cause on each line	2002		0	201 A		Land	W.	م	Interval Between Onset and Death
	Ph ysician /Medical		disease or condition resulting in death)	a	ge	Twe							years
	Examiner			Due to for as a	abusequ.	فالعظا	1						year
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	conseque	ence of):		- 9	0.	1	P		
	outed Id ransit	Examiner	Cause (Disease or injury that initiated events	a A	~		<u> </u>	4	re	الما	10	July 7	
ó	an ar irial-t	EX	resulting in death) Last	Due to (or as a	conseque	ence of):							
8760,	icate be executed physician and s the burial-transit	dicai	,	d									
9	eath certific attending pl	Med	IF FEMALE:										
Вох	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 ☐ Fetal c	death 3 □E	ctopic pregnancy	/			2:	 Date of deliving Month 	rery Day Year
0	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□ Unknown	time of dea	ath 5∐C	other (specify) _						,
۵_	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit		Part II. Other significant condition	s contributing to death bu	t not result	tina in the und	erlving cause giv	ren in Part I.		23e. Did to	bacco us	se contribute to	the cause of death?
Vital Records,	signed d be del	d by					, ,			1 🗆 Y	es 2	3 □ Pro	bably 4 Dunknown
200	w requir been si should	ete								24a. Was	20	24h Wara aut	opsy findings available
Re	ne fav s has ge 2	Completed			**					autop perfor	sy rmed?	prior to co	ompletion of cause of
a		e Co	25. Was case referred to medical	31				00 81	(D) . (6		2V No	1 🗆 Yes	2□ No
	ysicie is cert direct	To B	examiner?	Hospital: 1 ☐ Inpatier	+ 2□E	R/Outpatient	3 DOA Oth	OF.		Check only of 5 ☐ Resid		Other (Speci	Hopica
ō	a Phy er this		27 Manner of Death	28a. Date of Injury	/ 2	28b. Time of	28c. Injur			d. Describe h			y wousy
<u>lo</u>	tending Ph leath. tor: After th the funeral	atlo	Natural 5 Pending		rear)	Injury	1	k? Yes 2 ☐ No	,			•	
Division of	I or Attendi after death. Director: A	ific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At hom	ne, farm, stree	t, factory, office		28f.	Location (S City or Tow		Number or Run	al Route Number,
Ö	itel or A rs after el Dira ed in by	Certification:		building, old	. (0,000,1)/					0.19 0. 1011			
	To the Hospitel or Attending Physicien: within 24 hours alter death. To the Funerel Director: After this certifical completely filled in by the funeral director,	edical	(Check only 2 Medical E	Physician: To the best o xaminer: On the basis of	examination	ledge, death o	ccurred at the tir	ne, date and p pinion, death	place, and	due to the dat the time, o	cause(s) a	and manner as s place, and due t	stated. o the cause(s)
	the the mplet	Med	29b. Signature and title of certifier	and manner stat	ed.	\	29c. Licens					signed (Month,	
	5 × 5 × 7		200. Organization and title of certifier	ton		5	200. Elodris	D291	No	1	n Jaio	10 C	Th 2004
,	h		20 4	the completed asset of	oth (ltc=- 1	12a\ /T - 5	(=+)	フラー	T	- 000:	+17	711 8	
	.)		30 Name and address of person w	Allo completed cause of de	CONTRACTOR 2	C AT	DDA	3,2	CIT	07/2	700	200	ND 21013
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	ire	4		VIC	W.	, - 1	111	100)
	Registr		APR 1	2 2005	40.	H A	wall s						

	•	For State Registrar	State of M	laryland /	-	artment of H		Mental Hy	giene Reg. No.	200	5	12328
		1. Decedent's Name (First, Middle	ə, Last)					2. Date of De	aath Day	Yea		3. Time of Death
Physicia /Medic		Burton	Doc	190H	, [TA		April	64	4 200	. 1	10:58PM
Examin		4a. Facility Name (If not institution	, give street and number		/	4b. City, Town, o	r Location of Death	n	4c.	County of De	eath	
		uni versity		land Hos		e E	Extrus					
Funeral		5. Social Security Number	6. Šex 7. A	ge (In yrs. last b		If Under 1 Year Months Days	Hours Min.	8. Date of Bi	av. Year)		Country)	
Director	,	558-34-4807	22 III 2 I	76	Yrs.			Sept.	18,1	928 No	rth	Carolina
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Lo	ocation					10d.	Inside City Limits
Mary f sho	ō	MD Anne	Arundel	Ann	apo	lic						1 ☐ Yes 2 🕅 No
the 28a-	Director	10e. Street and Number	Arunder	AIII	аро	10f. Zip Code			10g. Citi:	zen of What	Country'	?
ours after death with the Marylan ral', or Items 23a or 28a-f show Examinar must be notified at		1626 Trawler	Lane			21	1401		1	USA		
death	Funeral	11. Marital Status	12. Was Decedent	t Ever in U.S.	13.	Was Decedent of H		pecify Yes or No	-	14. Race - A		
or Ite		1 Never Married XXMarr				1 ⊡Yes 2 X □No	Specify:	o Ricari, etc.)		Black, W	Whit	
ours ours	d by	3 Widowed 4 Divorced	Year or Dates:	1947–67	<u>' </u>	10 165 20 140	Зреспу.			Specify:	MIITE	
72 hours after death w 72 hours after death w "natural", or items 23a	Completed	15. Deceden (Specify only higher	it's Education st grade completed)	16a	(Give	dent's Usual Occup kind of work done	during most of wor	rking	16b. Kir	nd of Busine	ss/Indus	try
han dithin	m J	Elementary/Secondary (0-12)	College (1-4or			DO NOT use retired	,					
ified within 72 hours after death with the Maryland Hygiene. Hygiene. Sther Hear "natural", or Items 23a or 28a-f show ent, Ire Macified Examinar must be notified.		17. Father's Name (First, Middle,	(4)	De	eren	se Market	18. Mother's Nar	ne /First Middle	Maiden	Defen	se	
ntal hed of	Be											
ie, wal ylail & Lizio-	ဥ	Burton Lee Do 19a Informant's Name/Relations	2.2	19	h Mailir	ng Address (Street		le Wadsw		Town State	a. Zip Co	nde)
d 2 s d 2 s th an th an trau		Mary Ann Dogg	, , , , , , , , , , , , , , , , , , , ,			Trawler						.55)
Heal Heal Heal Heal		20a. Method of Disposition	ett (wile)	20b, Place	of Dispo	sition (Name of		Date		cation - City		, State
ages nt of t: If it		1 Burial 2XXCremation 4 Donation 5 Other (S		9	-	matory or other place ematory	4-9	-05	Rol1	imore	MT	1
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Euneral Service		HCCIC			ss of Facility			LIMOLE	, 111	
Dep dem		Date 1	WIL			2. Name and Addre Hardesty				MD 2	1401	
		23a. Part1. Enter the dilease, or	complications that cause	ed the death. Do		12 Ridge I ter the mode of dyin				, MD 2	Ac	proximate
Dhysisian		shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.		1. 11					Or	terval Between nset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or a	s a consequence		TAH 1164	700				m	vinutes
Examiner			Acu		,	cardial	11 far	tron				and av
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	в а сопвациення	\vi):	açg-o igei	191100	21211			1	TI CHES
uted d ansit	Examiner	Cause (Disease or injury that initiated events	Coro	han a	art	en di	Seers					rears
an an an rial-tr		resulting in death) Last	Due to (or a	s a consequence	of):							,
cate be executed physician and the burial-transit	dicai		d									
Box box got lies that the state of the second secon	Med	IF FEMALE:										
ath ce	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal deat		Ectopic pregnancy	/		2	3d. Date of Month	delivery Da	v Year
the all	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a	at time of death	5 ∟	Other (specify)		·				,
by #	Ph)	Part II. Other significant condition	ons contributing to death	but not resulting	in the u	indertving cause giv	en in Part I	23e. Did	tobacco u	se contribute	to the c	ause of death?
signed d be del	by	Luca Cara		Dut Hot roouting		induriying daddo giv	OTT INT COLUMN		Yes 2			y 4 ⊠Unknown
w requir been si should	ompieted	- Touring car	,							1		
Has be law	npi							24a. Was		24b. Were prior death	to compl	findings available etion of cause of
t The	CO							1□ Yes	2 No	1 🗆 Y	es 2[□ No
Physician: Physician: r this certifica	Be	25. Was case referred to medica examiner?	Hospital:			oth and post Oth	26. Place of Dea					
Phys this	- To	27. Manner of Death	28a. Date of Inj		utpatier Time o	II 3H DOA	4 Norsing 1	lome 5 ☐ Res 28d. Describe			pecify)	
ding th. After	tion	Watural 5 ☐ Pendir		ay Year)	Injury	Wor	k? Yes 2 □ No	200. 200020		, , , , , , , , , , , , , , , , , , , ,		
Miten deat ctor: y the	lica	2 Accident investi 3 Suicide 6 Could	not be	niury - At home, 1	arm. sti	reet, factory, office		28f. Location	Street and	d Number or	Rural R	oute Number,
al or Attendin s after death. Il Director: Af id in by the fur	Certification:	4 Homicide	building, e	etc. (Specify)		, , , , , , , , , , , , , , , , , , , ,		City or To	wn, State))		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1 Certifyir	ng Physician: To the bes	st of my knowledg	ge, deat	h occurred at the tir	me, date and place	and due to the	cause(s)	and manner	as state	od.
ne Ho n 24 h na Fu	edicai	(Check only 2 Medical one)	Examiner: On the basis and manner s		nd/or in	vestigation, in my o	pinion, death occu	irred at the time.	, date and	place, and o	due to the	e cause(s)
To the Hospital within 24 hours a To the Funaral I completely filled	X	29b. Signature and title of certifie	" Attende	+ Phys	101,	29c. Licens	e number		29d. Date	a signed (Mo	onth, Day	v, Year)
0		Umoris	Cin A. Co	حائيه رم		Do	15562	40	Apr	116	214	2005
00		30. Name and address of person	who completed cause of	death (Item 23a	(Туре,	Print)	at the state of	•	0.00		-190121	
d		Marcia A. Corr	mo rumms	22.5.0	me	ene St.	Balam	in mi	> >	1201		
Sta		31. Date filed (Month, Day, Year)	32/Regis	strar's Signature	1	ante						
Registr	ar	APR 12	2005	150 50	1503	Star Montage						

		1 - For State Registrar	State of Marylar	-	rtment of H		Mental Hygie	4000	12329
Physicia /Medic		1. Decedent's Name (First, Middle, Last)	Duchon				2. Date of Death Month	Day Year	J 3:50 M
Examin		4a. Facility Name (If not institution, give	spital	. last birthday)	4b. City, Town, or Ball	Location of Deal		Satism 9. Bi	one City
Funeral Director			XM 2□F 48	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 12/17/19	66 Mo	ountry Visited Types of the Country Visited T
death with the Maryland ms 23a or 28a-f show	ctor	10a. State 10b. County MD Howard		ity, Town or Loca aurel	ation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
h with the	al Directo	10e. Street and Number 9440 Falling Water	s Court		10f. Zip Code 20723			. Citizen of What C JSA	Country?
in ter	by Funeral	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		as Decedent of H Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
within 72 hours at ne.	Completed	15. Decedent's Edu (Specify only highest grad		(Give ki	ent's Usual Occupi ind of work done of ONOT use retired	during most of wo	rking	o. Kind of Busines	
should be filed within nd Mental Hygiene.	To Be Co	12 17. Father's Name (First, Middle, Last) Charles G. DuCho	n.	Facili	ties Man		me (First, Middle, Mai	OCKHEED den Surname)	Martin
and 2 shousally and N n 27 is mailer trauman		19a. Informant's Name/Relationship (Ty Sara J. DuChan /					ural Route Number, C Cowrt. Law		Zip Code) ILand 20723
Deficiency of permit. Pages 1 are Department of Health programment of Health programment in the pages.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		ition (Name of atory or other plac Cemetery		Date 2007	Location - City o	
Deficient Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licens		22.	Name and Addres	ss of Facility	leck Funer	ial Home.	~
Physician /Medical		23. Part1. Ente, the disease, or comp shock, or heart failure. List only or Immediate Sause Final disease or condition resulting in death)	cations at caused the dea	atic sp	the mode of dyin	8.7	c or respiratory arrest,		Approximate Interval Between Onset and Death
reate be executed physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect						
The law requires that the death certific the law requires that the death certific ate has been signed by the attending page 2 should be detached for use as it	hysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Feti 4 Pregnant at time of 6 9 Unknown	al death 3 □E	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
w requires that been signed by should be deta	leted by Ph	Part II. Other significant conditions con	ntributing to death but not re	sulting in the und	derlying cause give	en in Part I.	23e. Did tobac		to the cause of death? Probably 4 @Unknown
	Complet						24a. Was an autopsy performed	prior to death?	autopsy findings available completion of cause of s 2 No
ysician: T	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	tospital:	ER/Outpatient	3□ DOA Othe	An .	ath (Check only one) Home 5 Residence	e 6 □Other (Sp.	ecify)
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	ertification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🔲		28d. Describe how i	njury occurred	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	O	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci sician: To the best of my kn	· fy)		no data and als	28f. Location (Stree City or Town, S	ta te)	
he Hos in 24 hc he Fun pletely (edical	(Check only 2 Medical Examinations)	ner: On the basis of examination and manner stated.	ation and/or inve	estigation, in my of	pinion, death occi	er, and due to the caus	and place, and du	e to the cause(s)
Tot Toth	M	29b. Signature and the of certifier			29c. License			Date signed (Mor	
20		30. Name and address of person who co Peter H. Gorn		m 23a) (Type, P	rint) Kerne	on Drive	2 Beltin	ore, mi) 21207
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	atuly Go	ade)				

			1 - State of Maryland /		artmen rtificate			and M	-	gien Reg. No	/1115	12	330
	Physic	an	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ath		3. Time	of Death
V.	/Medi		George S. Dailey						April	9,	2005 Year	2:4	5 P M
	Exami	ner	4a. Facility Name (If not institution, give street and number)		4b. City,		Location o			40	. County of Dea		
			MD Masonic Homes 5. Social Security Number 6. Sex 7. Age (In vrs. last.	bint to 1	If Under		keysv					imore	
	Funeral Director		261-44-1757 ¹ X ¹ X ² □ F 95	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Jan. 1	r, Year,	9. Bird Co 1910 A	thplace (State ountry) \L	or Foreign
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Lo	cation							10d. Inside (City Limite
	Mary f sh	ξ	MD Baltimore Coo	ckevs	sville	2							s 2√√No
	r 28a	Director	10e. Street and Number		10f. Zip					10a. Ci	tizen of What Co		
	th wit	ai D	202 Cranbrook Road			21	030				USA	•	
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Deced	ent of Hi	spanic Orig	in? (Spe	cify Yes or No- Rican, etc.)		14. Race - Ame		
36	s afte , or It	by Fu	If Van Cina		I □ Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,	1.0411, 010.)		Black, White Specify: W		
Ö	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Examinat must be notified at	ed b											
5.	n na Aedic	Completed	(Specify only highest grade completed)	(Give	lent's Usua kind of wor DO NOT us	k done d	urina most	of working	ng	16b. K	ind of Business/	Industry	
212	d with	mo	Elementary/Secondary (0-12) College (1-4or 5+) N/A	Ar	my	,				M	ilitary		
פ	al Hyg	3e C	17. Father's Name (First, Middle, Last)				18. Mother	's Name	(First, Middle,				
ylai	Ment Ment arked atic e	To Be	John Joseph Dailey				Ma:	rgar	et Caro	lin	e Herri	ng	
Maryland 21215-0036	2 sho										or Town, State, Z		
	1 and tealth om 27 ther to				-		Road				MD 2103		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examtine must be realified at ance.		1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State ☐ Injon	tery, crem	natory or oti	her place	' A		16,	20c. Lo	ocation - City or	Town, State	
薑	artme ortent injury		'4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Liponsee	n Cem	netery	7	of Facility	_ 20	05	Van	ce, Alab	oama	
Ba	Dep Impo		Michael J. Flagle						of Dul	ane	y Valley MD 2109	, Inc.	
			23a. Part1. Enter the disease, or complications that caused the death. Do	not ente	or the mode	ador of dying	11.a . Ko , such as c	oad '	respiratory arr	m 🎾 🔝 est,	MD 21093	Approxima	te
	Physician	8 12	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		Da	. +						Interval Bei Onset and	
	/Medical		resulting in death) a. Due to (or as a consequence	e of):	Den Di	ne	er						
	Examiner		Sequentially list conditions. b. Vascu		- DI	Secu	2e					year	1.
	ad sit	line	Sequentially list conditions, if any lea and to immediate cause. Enter Underlying Cause (Disease or injury	a offy								-	
•	xecut and	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence	e of).	_								
8760,	cate be executed physician and the burial-transit	dical E		,,-									
Ø	g phys as the	edic	U.										
Вох	leath certific attending p	M/UE	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat	h 2□						1	23d. Date of deliv	very	
о. В	The law requires that the death certific to has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Ves a		Ectopic pre Other (spe						Month	Day 3	Year
۵.	w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting	in the un	derhing car	ISA ANYAR	io Part I		230 Did tob	2000	se contribute to	the severe of d	40.04.7
ds,	uires signe id be	d by	Renal Ousefform Coroners an	ten	DISa	عدد عدد . عد	i iii Fan i.		1 🗆 Ye			bably 4	
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ā		BeC	25. Was case referred to medical				OF Place o	of Dooth	1 Yes 2		1 ☐ Yes	2 No	
>	nysici lis ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient	3□ DOA	Oth -					S □Other (Speci	ifv)	
0	ng Pl		27. Manner of Death 28a. Date of Injury 28b. 1 ✓ Natural 5 ☐ Pending (Month, Day Year) 28b.	Time of Injury	28	c. Injury a Work?		7.7	d. Describe ho			,,	
Sio	tendi death. tor: A the fu	cati	2 Accident investigation		M	1.7	s 2∐No	-					
Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours after death as a first or after this certified completely filled in by the funeral director; to the control of the	Certification:	4 Homicide determined 28e. Place of Injury - At home, f building, etc. (Specify)	arm, stree	et, factory,	office		28	If. Location (Str City or Town	eet and , State)	d Number or Rur	al Route Num	ber,
	spite		29a. Certifier 15 Certifying Physician: To the best of my knowledg	e. death	occurred at	the time	date and	place an	d due to the ca	usa/s)	and manner as a	stated	
	he Ho n 24 t he Fu oletely	edical	one) and manner stated.	nd/or inve	estigation, in	n my opir	nion, death	occurred	at the time, da	te and	place, and due t	to the cause(s))
		Ž	29b. Signature and title of certifier R.T. Full W. 30. Name and address of person who completed cause of death (Item 23a) 20 Bart LI Barty, MD. \$50 P Bart 31. Date filed (Month, Day, Year) APR 1 2 2005		29c.	License i	number		29	d. Date	signed (Month,	Day, Year)	
,	19		R.T. Jeluto, Ms.		J	214	16 Y			4/	11/05		
4	1		30. Name and address of person who completed cause of death (Item 23a)	(Type, P	rint)		1/10-32			1	not recover the		
•			20 Blut LiBerty, MD. 370 Baul 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature	_ 51	B	all	0,10	rel	2122	Υ			
	Stat Registra		APR 1 2 2005	Son	de								
			LILLY THE THE PARTY OF THE PART	1									

State of Maryland / Department of Health and Mental Hygier 🔒 🕦 🖰 5 1233 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Shirley DAUIS 2005 12.38 AM 04 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOME RANDALLSTOWN BALTIMORE NURSING FUTURE CARE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 09 - 20 - 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□M 2**Ø**F Months Days Hours Min. 369.40.1565 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State f ehow itam 27 is marked other then "natural", or items 23a or 28e-1 eho: other traumatic event, the Madical Exambar must be notified at 1 Yes 2 No BALTIMORE Director MD GWYNN OAK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ROAD by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (#-4or 5+) HOME 10-TH GRADE NURSING ASSISTANT NURSING NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UK Mental PAT CHARLES KENNINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2112 SUNBRIAR RD. Date CHARLES Health tem 27 BALD . MD SOKDAN 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of importent: if it eny injury or o 04.12.05 BALTO. MD MT. XION ¹ 4 □ Donation 5 □ Other (Specify) VAUGHN C GREENE FUNERAL SERVICE 21. Signature of Funer Fervice Licensee 5151 BALTO NATL PIKE, BALTO MO aura 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head define. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician CEREBROVASCULAR ALC IDENT /Medical **Examiner** HYPERTENSION Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, DEEP VE NOUS THROMBOSIS 1 Yes 2 No 3 Probably 4 Illanknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 st autopsy performed? 1 ☐ Yes 2 PNO funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; After Hospitel or Attending 1 DNatural 5 Pending in 24 hours after deam.
the Funerel Director: Alt 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔽 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 04-08-2005 D0059107 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTSIDE 2 bor LIBERTY HEIGHTS AVENUE BALTIMORE MO 21215 UMA MEDICAL GROUP 31. Date filed (Month, Day, Year) State 1 2 2005 Registrar

			1 - For State Registrar	State of Marylan		artment of H			4000	12332
	٠.	and .	Decedent's Name (First, Middle, Last,)				2. Date of Death		3. Time of Death
	Physici /Medi		GERALDINE DA	Y				April 6	Day Year	08:47 A.M
	Examir		4a. Facility Name (If not institution, give 3809 Edmondson Ave	street and number) enue		4b. City, Town, or Balt:			4c. County of Death	
	Funeral		Social Security Number 6. Security Number	0 ()	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Birth	place (State or Foreign
	Director		FIG. EU. YERLO	M 200 F 5	Yrs.	Widitis Days	Hours Min.	OG · A · 19	53	MD MD
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Man a-f sh	tor	MD NA	BAL	TIMOR	E				1 ∰Yes 2 No
	th the	Director	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Cou	untry?
	ath wi	ral	3809 EDMONDS	N AVENUE		2122	o		USA	
	ltams ner de	Funeral	11. Marital Status 1⊠Never Married 2□ Married	 Was Decedent Ever in U. Armed Forces? 		Vas Decedent of Hi Yes, specify Cubai	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
920	urs aff	þ	3 Widowed 4 Divorced	1	1	☐Yes 2 No	Specify:		Specify:	NOV
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show ited Examiner: MSI be traffied at	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	ent's Usual Occupa	tion	16	6b. Kind of Business/Ir	ndustry
2	Athin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	kind of work done d OO NOT use retired)	uring most of wor		L-2 - 2.	2
2	illed w Hygiel thar ti nt, It		17. Father's Name (First, Middle, Last)	NA		AIDE	40.14.1.1.1.1.			fre
Maryland	d be i ental I cad o	To Be	VINCENT DAY,	R.P.			18. Mothers Nan	ne (First, Middle, Ma	aiden Sumame)	
ary	shou ind M s mar	ř	19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailin	g Address (Street a	nd Number or Ru	ral Route Number, (City or Town, State, Zi	n Code)
Ž,	and 2 balth a n 27 ls		AUCE DAY		3809	EDMON	DSON A	VF. BAI	TO NO	21279
ore	of He of He If itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		ace of Dispos	sition (Name of atory or other place)	Date 20	c. Location - City or T	own, State
Baltimore,	trent tant: tant:		`4 □ Donation 5 □ Other (Specify)	KIN		ARK	04-1	2-05 R	ANDHUSTO	CM, NW
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparment of Health and Mental Hygiene. [Department of Health and Mental Hygiene. [Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination and Department once.		21. Signature of Funeral Service License		VAI 5 F	Name and Address	GREENE	FUNERA KE BALI	L SERVICE	320
	. 11		23a. Part1. Enter the disease, or complishock, or hear failure. List only or	cations that caused the death	. Do not ente	r the mode of dying	, such as cardiac	or respiratory arres	1, 1110 21/	Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Hyperfector Siv		diovasci	1kr di	SUR		Interval Between Onset and Death
	Examiner	Ш	Sequentially list conditions, b							
	sit s	iner	1 any leading to immediate cause. Enter Underlying	Dub to (or as a nonsequ	erice of):					
	xecute and II-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):			·		
68760,	ficate ba executed physician and is the burial-transit			222 10 (0) 43 2 301/3042	31100 01).					
89	tificate ig phy as the	ledical					-			174
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 □	Ectopic pregnancy Other (specify)			23d. Date of deliver	ery Day Year
Р. О	hat th od by t detach	Phy	9 AUnknown Part II. Other significant conditions con		laine in although					
Vital Records,	quires that an signed to uld be det	leted by	842hre	mouning to death but not resul	ung in the und	enying cause giver	in Parti.		cco use contribute to the 2 No 3 Prob	(4)
၀ ၀	law requir as been si 2 should	plete						24a. Was an	24b. Were auto	psy findings available
	W CT	Compl						autopsy performed	prior to co	impletion of cause of
/Ita	ilcian: The certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Deal	h (Check only one)	1140 1 1 103	20 110
0	hya this al dii	2	1X Yes 2 No H		R/Outpatient	3□ DOA Other	4 Nursing Ho	ome 5 🗆 Residenc		At scene
	ding I h. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work? M 1 7	at es 2 □ No	28d. Describe how	injury occurred	
DIVISION	l or Attanding after death. Diractor: After in by the fune.	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At hon	ne, farm, stree		55 2 110	28f. Location (Stree	at and Number or Rura	I Route Number
בֿ	tal or rs afte al Dira ed in b	Certification:	4 Homicide determined	building, etc. (Specify)		,,,		City or Town, S	State)	, rodio romodi,
	To the Hospital or At within 24 hours after of To the Funeral Diract completely filled in by	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phys 2 ☑ Medical Examin	cian: To the best of my know er: On the basis of examination and manner stated.	rledge, death on and/or inve	occurred at the time estigation, in my opin	, date and place, nion, death occur	and due to the caus red at the time, date	se(s) and manner as si and place, and due to	ated. the cause(s)
i	To the within To the comple	M	29b. Signature and title of certifier	210		29c. License		29d.	Date signed (Month,	Day, Year)
0	4		Calvill	-414		OCM	ٿ	Apr	ril 7, 200	5
6			30. Name and address of person who cor	npleted cause of death (Item :	23a) (Type, P	rint) 111 Per	n Stree	t Baltimo	re, Maryla	nd 21201
	Stat	е	31. Date filed (Month, Day, Year)	39. Registrar's Signatu	ire					
Dur.	Registra	· 30	APR 1 2 2005	Jednes B.	grey	w .				

DHMH 17 Rev 1/2001

	1	For State Registrar	State o	f Maryland / D	-	rtment tificate			ind M		giene () ()5	12333
Physicia	n	1. Decedent's Name (First, Middle Michael	, Last) Elefante							2. Date of Dea		00′5°ar	3. Time of Death 4:45p M
/Medica Examine		4a. Fecility Name (If not institution Collington Num	-					Location o			4c. Count		eorge
Funeral Director		5. Social Security Number 135-03-9850	6. Sex XXM 2□ F	7. Age (In yrs. last birt	thday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 02-11	_1917	9. Birth Cou New	place (State or Foreign intry) ark, NJ
	-	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Towr	n or Lo	cation							10d. Inside City Limits
8a-fst	cto		nce George	e Mito	chel	lsvi						1	1 Yes 2 No
with the Sa or 2	Dire	10e. Street and Number 10450 Lottsfor	rd Rd. Apt	263		10f. Zip	0721				10g. Citizen of USA	What Cou	intry?
JS sall, o	by Fur	11. Marital Status 1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	² □Nº 1945		Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	Bla	ce - Americk, White	
21215-0036 of within 72 hours aft giene. er than "natural", or it in Medical Exert.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed) College (*	1-4or 5+)	(Give .	ient's Usua kind of wor DO NOT us	k doné d e retired,	uring most)	of worki	ng	16b. Kind of E		
Maryland 2 Ind 2 should be filed Ith and Menta Hyg 27 is marked other traumatic event,	To Be C	17. Father's Name (First, Middle, Alfredo Elefar	•	, 300				18. Mothe		(First, Middle, a Stons		me)	
Mary 12 sho h and I 7 is me traume		19a. Informant's Name/Relationsh Becky Elefante		19b.		100				Apt 263			p Code) ille MD
Baltimore, Marylar permit. Pages 1 and 2 should be Oppa front of Health and Manha Important: If item 27 is marked any injury or other traumatic events.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 3 Other (S)	3 □Removal from	State 20b. Place of cemeter.	Dispo	sition (Nam	ne of ther place	9)	D	-	20c. Location Beltsv	- City or T	own, State
Saltir eermt. P Separtme mportan incy injur	-	21. Signature of Funeral Service	4	Dant	1		d'une	ral &	Cre	mation			
Physician		23 Pam. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on e	caused the death. Do reach line.						r Sprin r respiratory ari		910_	Approximate Interval Between Onset and Death 2 mo
/Medical Examiner		resulting in death)	Due to	orasaconsequence cardial Inf	•	rtion							2 mo
√2	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty Cause (Disease or injury	Due to	orasa consequence of eroscleroti	of):		Die	2260					20 years
68760, friting the personal department of physician and as the burial-transit	ilcal Examiner	that initiated events resulting in death) Last	C	(or as a consequence of			D13						20 years
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live t	tcome of pregnancy birth 2 Fetal death nant at time of death own		Ectopic pro						ate of delivonth	rery Day Year
ds, Puires that signed b	by	Part II. Other significant condition Chronic Obstru	•	•			ause give	n in Part I.		23e. Did to		tribute to t	the cause of death?
Vital Records, sicien: The law requires to certificate has been signe rector, page 2 should be e	ompleted	Scoliosis Type				- X - L - C -				24a. Was a	sy	prior to co	opsy findings available ompletion of cause of
Vital Re	O .	Hiatal Hernia									₹ XNo	death? 1 🔲 Yes	2 □ No
f Vita	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ★ No	Hospital:	Inpatient 2 ER/Ou	tpatien	it 3 🗆 DO	A Othe			n <i>(Check only or</i> me 5 ☐ Resid		ner (Speci	fy)
on of ding Phy h, After this funeral d	tion:	27. Manner of Death 1 □ Natural 5 □ Pendin 2 □ Accident investig			Time of njury	M 2	8c. Injury Work	at ? /es 2 🗆 N		28d. Describe h	ow injury occu	rred	
Division I or Attending after death. Director: Afte	Certification:	3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place	e of Injury - At home, faing, etc. (Specify)	rm, str	eet, factory	, office			28f. Location (S City or Tow		ber or Rur	al Route Number,
Divisit To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	Examiner: On the b	be best of my knowledge asis of examination and ner stated.	death dor inv	occurred vestigation,	at the tim	e, date and pinion, deat	d place, a	and due to the ded at the time, o	ause(s) and m late and place,	anner as s	stated. to the cause(s)
To the within To the comple	Me	29b. Signature and the of certifier	r			290	License	number		2	29d. Date signe		
1/4		30. Name and address of person	who completed car	of death (Item 22c) /	(Type	Print)	D46	834			03-22-	-2005	
10		Mary Ruth Lop	ez 7525 G	reenway Cir			eenb	elt M	D 20	772			
Stat Registra	_	31. Date filed (Month, Day, Year)	R 1 2 200	Registrar Signature	K	Ap	w/L	•					

			r lease 1	State of Marylar				•	•	12334
			1 - For State Registrar			rtificate of l			J. No.	16004
			1. Decedent's Name (First, Middle, Last)	- 1	/		_	2. Date of Death Month		3. Time of Death
	Physic /Medi		John F	Engle	na	rat		April	09 2005	7:48 P ^M
	Examir		4a. Facility Name (If not institution, give s	/			Location of Death		4c. County of Deat	
			North Arundel Hosp		1	Glen Bi	UMNIE If Under 24 Hrs.	0.5 (5:4)	Anne Arı	
	Funeral Director		219-10-3082	7. Age (In yrs.	78 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,) Aug. 10,	(ear) 1926 Ma	hplace (State or Foreign aryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	Mary	jo	Maryland Anne Aru	ndol	Pasade	nn a				1 ☐ Yes 2) No
	r 28e	rec	10e. Street and Number	nder	Tusuut	10f. Zip Code		100	g. Citizen of What Co	ountry?
	h with	a D	111 Cloverhill	Road		2.	1122		USA	
	ems :	ner		Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other then *natural'; or Items 23e or 28e-f show any figury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Mary Yes 2 □ No If Yes, Give		1 ☐ Yes 2 No	Specify:	,	Specify:	White
21215-0036	hour tural	ed b	15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occupa	ation	16	Sb. Kind of Business/	
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212	d with giene.	mo;	Elementary/Secondary (0-12)	College (1-4or 5+)	Cł	necker			Railroad	Trasportatio
bu	al Hyg	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		
ylaı	should be filed vind Mental Hygie marked other umatic event, In	고 인	John Engleh				Alice	Α.	Kuntz	
₩.	2 sho and is my		19a. Informant's Name/Relationship (Typ						City or Town, State, 2	
_	1 and Health em 27 ther tr	1 3	Barbara Ramsey -ne		_	osition (Name of			na, MD 211	
Baltimore,	Pages nent of H int: If ite		1 Burial 2 ☐ Cremation 3 ☐ Re	moval from State	semetery, crei	matory or other place	9)			
Ħ	permit. Pag Department Important: I any Injury o	1	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice Fee	11	The state of the s	[] Cemete			Baltimore,	
Ва	permit. Departrimports imports any inju) Misch III	14/1/	/)				s Funeral na, MD 211	Home, P.A.
			23a. Part . Enter the disease, or complic shock, or heart failure. List only on	ations that caused the deat						Approximate Interval Between
	Prysician	, .	Immediate Cause (Final disease or condition	a cause on each line.	dias	Anh	Muria			Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq			· · · · · · · · · · · · · · · · · · ·			Y FULL COS
4	Examiner		Sequentially list conditions b.							
5	sit sit	lnei	Sequentially list conditions, if any, leading to immediate cause Final thourships Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):					}
	and and Il-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
760,	ate be executed hysician and he burial-transit	calE	d							
687	ificate g phy: as the									
ŏ	leath certificat attending phy i for use as thi	M/us	23b. was decedent pregnant	c. If yes, outcome of pregna		Ectopic pregnancy			23d. Date of del	
. B	e deat	Physician/Med	in the past 12 months?	4☐Pregnant at time of d		Other (specify)			Month	Day Year
P.0	that the de led by the a detached t		9 ☐ Unknown Part II. Other significant conditions confi	sibuting to doub but not so	ulting in the L	adarhijan anuna aus	o in Dard I	23a Did toba	cco use contribute to	the cause of death?
ecords,	be ig	d by	Sepsin	induling to death but fileties	aiting in the a	riderlying cause give	mili r aiti.			obably 4 □Unknown
cor	w requir	Completed	V					24a. Was an	24b. Were au	topsy findings available
Re	The lav	dwo			2 212			autopsy performe	prior to death?	completion of cause of
		0	25. Was case referred to medical				26. Place of Death	1 ☐ Yes 2) (Check only one)	No 1 □ Yes	2 No
of V	S S D	To B	examiner? 1 ☐ Yes 2 ☑No	ospital: 1 🗌 Inpatient 2 🔀	ER/Outpatien	nt 3 DOA Othe	9r: 4☐ Nursing Ho	me 5 Residenc	ce 6 Other (Spec	cify)
0 0	ding Ph h. After thi funeral		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	.?	28d. Describe how	injury occurred	
sio	ten leat tor: the	catl	2 Accident investigation 3 Suicide 6 Could not be				/es 2□No	006 1 (01	-1	- I G A- W A-
Division	i or Attendate after death	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)	eet, factory, office		City or Town,	et and Number or Ru State)	rai Houte Number,
_	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Attercompletely filled in by the funer		29a. Certifier 1 Certifying Phys	cian: To the best of my kno	wiedge, deati	n occurred at the tim	e, date and place,	and due to the cau	se(s) and manner as	stated.
	To the Hospital within 24 hours To the Funerel completely filled	Medical	(Check only 2 Medical Examin one)	er: On the basis of examina and manner stated.	tion and/or in	vestigation, in my op	inion, death occurr	ed at the time, date	and place, and due	to the cause(s)
	To the To the comple	Ž	29b. Signature and title of certifier			29c. License			. Date signed (Month	
•	\sim		Market	. N. v.		12-6	1220	11	prec 11/2	.033
	10		30. Name and address of person who cor		n 23a) (Type.	Print) 3 2.5	Mazzite	(Donice	pril 11,2 , Swite) 21531	208
	1		DR EXTENSE 31. Date filed (Marth) Day, Tear 300		iture	80	sec Bro	nie Mi) 2108/	
	Sta Registi	14	1. K. T. Z. 200.	32 Registrar's Signa	K A	self o				

			State of Maryland	l / Depa		f Health	and M	ental Hyg	_	12335
	[©] Physici	an	Decedent's Name (First, Middle, Last) DAISY P. FIT	rzhugh	ī			2. Date of Dea Month APRIL		3. Time of Death 20:32 M
	/Medic Examir	cal	DAISY P. FT. 4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL	[2,1100]	4b. City, Tov	vn, or Location	n of Death	ALKIL	4c. County of De	
	Funeral Director		5. Social Security Number 229-20-3011 6. Sex 1 M 2 F 79	st <i>birthday)</i> Yrs.	If Under 1 Y Months D	ear If Unders	er 24 Hrs. Min,	8. Date of Birth (Month, Day 2-26-1		irthplace (State or Foreign Country) rginia
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation					10d. Inside City Limits
	e Man	ctor	Har y raina	ltimor	·e					1. Ves 2 No
	with the	Dire	10e. Street and Number 1437 Williams Street		10f. Zip Co	de 21230			Og. Citizen of What Onited Sta	
	ms 23	neral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent			city Yes or No- Rican, etc.)		nencan Indian,
36	within 72 hours after death with the Maryland ane. than "natural", or Itams 23a or 28a-f show he Madical Exertine result be notified at	Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		Yes 2	L		nicari, etc.)	Specify:	Inited States
21215-0036	2 hour	ted b	15. Decedent's Education	16a. Deced	ent's Usual O	ccupation			16b. Kind of Busines	
215	within 72 iene. than "nu the Madi	npie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. E	kind of work d OO NOT use re	one during m etired)	ost of workir	ng	مأم شريات على	Chap
	filed w Hygier thar th		7 years n/a	Sales	3	18. Mot	her's Name	(First, Middle, I	Sandwich Maiden Sumame)	Silop
lan	ould be Mental arkad o	To Be	Robert Stevens			1		Warwick		
Maryland	2 should and Men Is marka	-	19a. Informant's Name/Relationship (Type, Print)						r, City or Town, State Maryland	, Zip Code) 21230
	1 and Health tam 27		Clifton E. Fitzhugh (son) 20a. Method of Disposition 20b. Pla		ATTULE sition (Name of natory or other				20c. Location - City of	
Ē	Pages nent of nt: If it		Deliberial 2 Cremation 3 Chemoval non state		en Mem.	I	4-11-	2005	Glen Burn	ie, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depurment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show apportant in item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Madical Exertiner must be notified at once.		21. Signature of Funeral Service Licenses J. Wayne Osterlin	Mc	Name and A	deress of Fac	ak Fu	neral H	ome, P.A.	1 21230
	S. F.		23a. Part1. Enter the clause, or complications that caused the death, shock, or heart folium. List only one cause on each line.							Approximate Interval Between Onset and Death
	Physician /Medical		Immediate disease or condition resulting in death) a. Curultuc pue to (or as a consequence)		ryth.	mia				mins
	Examiner		Dilutel		mo	way	thy			6mos
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		1	-		3	-0.00	E
9,0	e be executed sician and e burial-transit	Examiner	that initiated events resulting in death) Last c. Hunch Fensou		en sc	Worker.	and	3003700	ur Diseus	3413
3760,	ate be hysicia he bur	cal	d							
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Thio 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dear 9 ☐ Unknown	leath 3 🗌	Ectopic pregn				23d. Date of d Month	elivery D <i>a</i> y Year
rds, P.	w requires that been signed by should be deta		Part II. Other significant conditions contributing to death but not result	ing in the un	iderlying caus	e given in Par	t I.	23e. Did tot	~/	to the cause of death? Probably 4 □Unknown
Il Records,	The law recate has bee page 2 sho	Completed by	L					24a. Was a autops perform	y prior to ned? death	autopsy findings available completion of cause of as 2 X No
Vital	iysician: Thinis certificate director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 2 2 4 Hospital: 1 Inpatient 2 4	R/Outpatient	3 DOA	Othor		(Check only on	ence 6 □Other (Sp	anif d
on of	iding Phys th. : After this funeral di	tlon; To		8b. Time of Injury	28c.	Injury at Work? 1 Yes 2	2		ow injury occurred	өспу)
Division	al or Attendir satter death. I Diractor: Af d in by the fu	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, of	fice	2	8f. Location (St City or Town	reet and Number or i n, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certification in the Funaral Director: After this certification in the funaral director.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know a property one) 1 Medical Examiner: On the basis of examination and manner stated.	edge, death in and/or inv	occurred at the	ne time, date i my opinion, de	and place, a eath occurre	nd due to the ca	ause(s) and manner a ate and place, and di	as stated. ue to the cause(s)
	To the within comp	Me	29b. Signature and title of certifier		29c. Lie	394			9d. Date signed (Mod	
	10		30. Name and address of person who completed cause of death (Item 2		Print)	φ, α	eltim	ere m	Hard 7,	O
•	Sta	ite	31 Date filed (Month, Day, Year) 32. Registrar's Signatu	re		1				
	Registr	5 G	APR 1 2 2005 See &	Appa	W					

Director Variable Parameter Paramet	
Daniel A. Fowler, Jr. April 6, 2005	3. Time of Death
4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel Anne Arundel Anne Arundel Funeral Director 5. Social Security Number 244-42-7638 110 M 2 F 72 Yrs. Usual Residence of Decedent 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel Anne Arun	1508 M
Director 244-42-7638 Usual Residence of Decedent Director Usual Residence of Decedent	le1
	place (State or Foreign htry) h_Carolina
Maryland Anne Arundel Pasadena 106. Street and Number 106. Street	I0d. fnside City Limits
109. Street and Number 8035 Woodholme Circle 11. Marital Status 1 Never Married 20 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 20 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16. Zip Code 21122 10. Zip Code 21122 10. Zip Code 21122 10. Zip Code 10. Zip Code 21122 11. Marital Status 1 Never Married 20 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use relired) 109. Citizen of What Cour United State 14. Race - Americ Black, White, Specify: Widows American, Puerto Rican, etc.) 16b. Kind of Business/Inc. 16b. Kind of Business/Inc.	1 □ Yes 2 12 No
8035 Woodholme Circle 21122 United State 8036 Woodholme Circle 21122 United State 8036 Woodholme Circle 11. Marital Status 1	
11. Marital Status	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	
(Give kind of work done during most or working life. DO NOT use retired) College (1-4or 5+)	
TO SEE SEE SEE SEE SEE SEE SEE SEE SEE SE	ing
Daniel A. Fowler, Sr. 17. Fatner's Name (First, Middle, Last) Daniel A. Fowler, Sr. Bessie Conway	
Daniel A. Fowler, Sr. Daniel A. Fowler, Sr. Bessie Conway	Code)
Lyda R. Fowler (wife) 8035 Woodholme Cr. Pasadena, Maryland 21	1122
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory of other place) 1 Burial 2 Dicremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Euperal Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 22. Name and Address of Facility 21. Signature of Euperal Service Licensee	
Bayview Crematory 4-11-2005 Baltimore, N	Maryland
5. Wayne observation 3204 Mountain Rd. Lasadena, haryland	21122
23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear value. List only one cause on each line. Physician When the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear value. The form of the mode of dying, such as cardiac or respiratory arrest, shock, or hear value. The form of the mode of dying, such as cardiac or respiratory arrest, shock, or hear value.	Approximate Interval Between Onset and Death
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Spool of the part of the part 12 months? 1	ery Day Year
O = 1 Yes 2 No 9 Unknown	
Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the part II. 23e. Did tobacco use contribute to the part II.	ne cause of death?
Intestinal hemorrhage 1 yes 2 kg no 3 prob	pably 4 Unknown
24a. Was an autopsy performed? death? 1 Yes 218 No 1 Yes	psy findings available mpletion of cause of
performed? death? 1 Yes 2 15 No 1 Yes	2 No
To be detailed by the second of the second o	
1 Yes 2 No Property 2 Residence 6 Other (Specify Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 3 DOA 04.64. 4 Nursing Home 5 Residence 6 Other (Specify Work?) 28b. Time of Injury At Work? 4 Nursing Home 5 Residence 6 Other (Specify Work?) 28d. Describe how injury occurred Work?	γ)
C D D S S S S S S S S S S S S S S S S S	
23d. Date of delivery months of the past 12 months? 1 Yes 2 No No	il Route Number,
Part of the part	tated. the cause(s)
29c. License number 29d. Date signed (Month, 10) 29c. License number 29d. Date signed (Month, 10) 29d. Date signed (Month, 10)	Day, Year)
D46052 410/05	
30. Name and address of person who completed cause of death (Item 23a), (Type, Print) at Pourhway, annapolis, Mo	
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 1 2 2005	

Provided Book Provided State And Appliance of the Control of State Appliance of CRISSIS In HAMPOINDS LANK STATE AND APPLIANCE OF THE APPLIANCE				- FOI	-				nd Mental Hy	200	5 12337	
## PRILL OF 2005 77:00 P M SECURITY V. FOLD ## Script States (Froz mandated gives arrest and number) ## GENERAL STATES HAMMONDS LANE ## BROOKLYN PARK ##		9		Registrar AMEND ITEM #20a-	-c PER FH	<u>G845°</u>	<i>ነባ'291</i> €)' ታ	Peaul				
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10.5 State 10.0 Cory 10.					_				4 Hrs. 8. Date of Bir Min. (Month, Da March	17, 1927	9. Birthplace (State or Foreign Country) Maryland	
George W. Collins George W. Col		and			10c. City	, Town or Lo	cation				10d. Inside City Limits	
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George W. Collins George W. Col	212	ed withingiane.	Comp	7		Sausa	age Stuff	er		<u> </u>	•	
Physician (Medical Examinor) Page 1 Examinor Page 2 Page 2 Page 3	land	ild be file fental Hy rkad oth	Be]	Lola A. T	hompson		
Physician (Medical Examinor) Page 1 Examinor Page 2 Page 2 Page 3	Mary	12 shouh and N 7 is mai				19b. Mailir	Address (Street a	ndall	or Rural Route Numb	er, City or Town,	State, Zip Code) 21230	
Physician (Medical Examinor) Page 1 Examinor Page 2 Page 2 Page 3		ges 1 and of Heali If itam 2 or other		20a. Method of Disposition	20h P	lace of Disno	sition (Name of					
Physician (Medical Examinor) Party Sidian (Medical Examinor) Par	altim	mit. Pag partment portant: / injury o			Bay	V 22	. Name and Addres	s of Facility				
Physician (Medical Examiner) Recording in death) Part Li Unter significant conditions and an appearance of the cause of death of t	Ä	Pe T C S	130 East Fort Avenue, Baltimore, Maryland 2123									
Comparison of the control of the c		Physician		Shock, or heart failure. List only one cause immediate Cause (Final disease or condition	on each line.	rdial	. (Interval Between Onset and Death	
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Company of Death Continue C	Vita	ician: certific ector,	Be	examiner?			Othe	- 310°S				
State 28f. Location (Street and Number or Rural Route Number, building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number, City or Town, State) 29g. Location (Street and Number or Rural Route Number) 29g. Location (Street and Number or Rural Route Number) 29g. Location (Street and Number or Rural Route Number) 29g. Location (Street and Number or Rural Route Number) 29g. Location (Street and Number or Rural Route Number) 29g. Location (Street and Number o	of	Phys r this ral dii		27. Manner of Death 28a. [28b. Time of	28c. Injury	at				
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Yèar) 34. Registrar's Signature 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Yèar) 33. Registrar's Signature	ivislo	or Attandie ter death. iractor: Ai n by the fu	rtificatle	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At ho	ome, farm, str		Yes 2□N	28f. Location (er or Rural Route Number,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50de Moners mp 7845 Oakwood Glen Burnie, mp 21061 State 31. Date filed (Month, Day, Yèar) 34 Registrar's Signature		lospital of hours at unaral D		29a. Certifier (Check only 2 Medical Examiner: On the control of	o the best of my kno	wledge, death	n occurred at the tim	ne, date and	d place, and due to the	cause(s) and ma	inner as stated. and due to the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jude Muners mp 7845 Obtwood Glen Burnie, mp 21061 State 31. Date filed (Month, Day, Yèar) 32. Registrar's Signature		o the Hithin 24 o tha Formplete	Medi	one) and								
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State 31. Date filed (Month, Day, Year) 35. Registrar's Signature		V		- 1 .1.		23a) (Type,	Print)	مام)	n Barnia	ma	2/06/	
	•			31. Date filed (Month, Day, Year)			W.	- 2		(iii)	2,50	

			1- For Unpend Item 23a, 27, 28a-f per	Department me G842 Certificate	of Hes	alth and -05 ta eath	Mental Hyg	giene () ()5	12338
	K.		Decedent's Name (First, Middle, Last)				2. Date of Dea		Vear	3. Time of Death
	Physici /Medio		Zachary J. Forman				April	10, 200)5	11:28 PM
	Examir	ier	4a. Facility Name (If not institution, give street and number)	_		ocation of Dea	th		y of Death	1 1 0
	*		921 Blue Ridge Road		polis	5 f Under 24 Hrs	S O Data of Bird			ndel County
7/6	Funeral Director		5. Social Security Number 6. Sex 1 1 1 2			Hours Min	. (Month, Day	1977		place (State or Foreign
			Usual Residence of Decedent				FEB 11,	1977	Mass	achusetts
	yland		10a. State 10b. County 10c. City, Tow	vn or Location						10d. Inside City Limits
	e-fs	ctor	MD Anne Arundel	A	nnap	olis				1 ☐ Yes 2X No
	or 28	Funeral Director	10e. Street and Number	10f. Zip 0	Code			10g. Citizen of	What Cou	ntry?
	23e	rai	921 Blue Ridge Road		21401			US	A	
	lems	rue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decede If Yes, specif	nt of Hispa fy Cuban, I	anic Origin? (: Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Ra Bla	ce - Ameri	can Indian, etc.
36	rs afte	by F	1 ⚠ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2	No S	Specify:		Speci	fy: Wh	nite
21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther then "natural", or Items 23e or 28e-f show ont, the Medical Examinat must be notified at	edt		. Decedent's Usual	Occupatio	on		16b. Kind of E		
215	n n 72	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work life. DO NOT use	done duri retired)	ing most of wo	orking			,
21	glene grene or the	E O	12	Sales				Priva	te Bu	siness
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. item 27 is marked other then "naturat", or Items 23e or 28e-f show other treumetic event, Ite Medical Examinations is notified at	Be	17. Father's Name (First, Middle, Last)		18	3. Mother's Na	me (First, Middle,	Maiden Suma	me)	
yla	ould Men sarke	၉	Jeffrey S. Forman			-	gery Papp			
Mar	12 sh h and 7 is m treum			b. Mailing Address (2 Hunting				•	, State, Zip	Code)
	1 and 2 Health em 27		20a Method of Disposition 20b. Place of	of Disposition (Name	e of	ı neec	Date PIA	20c. Location	- City or To	own. State
nor	Pages nent of h ant: If its ury or of		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	ery, crematory or oth	ner place)	no! //	/12/05		•	
Baltimore,	그 든 분 층		21. Signatur of Funeral Service Licensee	Cremator 22. Name and			of MD,	Baltin -	iore,	MD
ñ	Depar Impo	9	Edward A Gregorchik	299 Fre	ıon S ederi	ociety ck Roa	of MD, . d Baltin	lnc. More. M	D 212	28
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.							Approximate Interval Between
	Friysician	ű ü	Immediate Cause (Final disease or condition Cocaine and Mor	phine Int	toxic	ation				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence	of):						
		i i	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	of):						
	uted d ansit	Examlner	cause. Enter Underlying Cause (Disease or injury							
0,	an an	Exa	resulting in death) Last C. Due to (or as a consequence	of):						
8760,	The law requires that the death certificate be executed the bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d							
9	leath certifical attending place as t	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy					2212		
Вох	atten for us	cian	in the past 12 months?	3 ☐ Ectopic preg					ite of delivi onth	ory Day Year
0	that the de ed by the detached	Physician/Me	1 Yes 2 No 9 Unknown							
5, Р.	signed by det	by P	Part II. Other significent conditions contributing to death but not resulting i	in the underlying cau	use given i	in Part I.	23e. Did to	bacco use con	tribute to t	ne cause of death?
ecords,	w require been si should b						1 🗆 Y	es 2 No	3 Prot	pably 4 Unknown
ec	e law r has be je 2 sh	Completed					24a. Was autop	sv	prior to co	psy findings available mpletion of cause of
al R							1 Yes	med? 2□No	death? 1 Yes	2□ No
Vital		Be	25. Was case referred to medical examiner? 1000 Hospital: Hospital:		Other		ath (Check only or			Α.
of		To To	27. Manner of Death 28a. Date of Injury 28b.	utpatient 3 DOA	c. Injury at		Home 5 Resid			w At scene_ unk
ion	Attending Ir death. sctor: After	atio	1 Natural 5 Pending investigation 2 Accident Foundation 4-10-05		Work? 1 ☐ Yes	2 X]No				
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)		office		28f. Location (S City or Tow	treet and Num. n. State) Q2	B111	e Ridge Dr.
	ospitel o hours aft unerel Di		Found at home				Annapoli	s, Md		
	To the Hospitel or Attent Swithin 24 hours after death To the Funerel Director: Completelly filled in by the	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge 2 ☑ Medicel Examiner: On the basis of examination are and manner stated.	nd/or investigation, i	n my opini	on, death occ	urred at the time, o	late and place,	and due to	the cause(s)
	Son To	2	29b. Signature and title of certifier) / / 29c.	OCME		4	9d. Date signe		
	of it		Tatrice Would-to	Work	OCME	2		Apr.L.	L II,	2005
5	J 62		30. Neme and address of person who completed cause of death (Item 23a)	(Type, Print)	1 Pan	n Stro	at Role	imoro	Mo1	01001
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	, -WII.		"I OCT	ci Dail.	niore,	naryl	anu 41401
	Regist	rar	30. Name and address of person who completed cause of death (Item 23a) AR (A) (A) (A) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	w to to	parti)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 23a b per doc 3846 8-10-05 yt.

Amend items 23a b per doc 3846 8-10-05 yt.

Physici /Medic		Registrar		Certificate of D	eath	Rag	. No.	1200
	*	1. Decedent's Name (First, Middle, La	ast)		2	. Date of Death Month	Day Yea	3. Time of Dea
		ARTHUR		FLIPPO	A	PRIL	9 200	
Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Lo			4c. County of De	eath
	1		Sex / 7. Age (In yrs. last t	BALTIN		5 · · · · / 5 · · · ·		
Funeral Director			Sex 7. Age (In yrs. last to 8.3		Hours Min.	Date of Birth (Month, Day, Y	-192 V	Birthplace (State or For
show	-	10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Lin
s 23e or 28a-f show ust be nutified at	Funeral Director	10e. Street and Number	ouer Do	10f. Zip Code		10g	Citizen of What	1 ☐ Yes 2 ¶
	eral D	16353 Washi	12. Was Decedent Ever in U.S.	V 23 (54	h. Van ar Na	USF	merican Indian,
or Items 23s	by Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give	13. Was Decedent of Hisp If Yes, specify Cuban, 1 Tes 2 No	Mexican, Puerto Ri	can, etc.)	Black, Wi	
"natural", adical Exp	ted b	3 Nowidowed 4 □ Divorced		a. Decedent's Usual Occupation		16	b. Kind of Busines	ss/Industry
r hauln and Mentar rygjene. Item 27 is marked other than "natural", or frem other traumatic event, the Medical Execution:	Completed	(Specify only highest grant (0-12)	College (1-4or 5+)	(Give kind of work done dur life. DO NOT use retired)	f the B	rord 1	Flipp	o Lumber
d other event,	Be	17. Father's Name (First, Middle, Last	" LI EI .	11	B. Mother's Name (First, Middle, Ma	iden Sumame)	, , , , , , , , , , , , , , , , , , ,
and merital Is marked o aumatic eve	2	19a. Informant's Name/Relationship	NKIIN FIPDC (Type, Print) 19	9b. Mailing Address (Street and	Number or Rural F	Rout Number, C	City or Town, State	, Zip Code)
item 27 Is other trau		T. Nelson	Flippo-Nephew/	2991 Fairvi	ewct.	Ashla	nd, va	23005
2 = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Special	☐Removal from State / ceme	of Disposition (Name of tery, crematory or other place)	en 4-14	-05	C. Location - City	or Town, State
Department Important: any injury once.		21. Signature of Funeral Service Lice	- Iuu	22. Name and Address	of Picility 4/12	5. W	ashing	oh thui
7 = 4 0		222 Part Enter the disease or con	that caused the death. D	_Keid fune	ral Hor.	ne Asi	hland,	VOL 2300 Approximate
A		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final	on each line.	Coll	apse	espiratory arresi		Interval Betwee
ysician Iedical		disease or condition resulting in death)	a. (AZDIOPUL! Due to (or as a consequence		LEST			1 DAY
aminer			b. Arrhythmia	A 01).				
	<u></u>							
10	ž.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):				
nd trans	amine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (of as a consequenc	·				
ian and urial-trans	l Examiner	Cause (Disease or injury	c Due to (or as a consequence	·				
physician and the burial-trans		that initiated events	Due to (of as a consequenc	·				
ding physician and se as the burial-transit	edical	Cause (Disease or injury that initiated events resulting in death) Last	C	·				
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			For State Registrar		State of	of Mar	*		rtment of fificate o	Health and f Death	Mental F	lygien Reg. N	4000	12340
ı	Div		Decedent's Name (Fi	irst, Middle, Lasi					<u>-</u>		2. Date of Month	Death		3. Time of Death
	Physicia /Medic		Andrew	Le	ster	Forti	ine				Apr	i1 5,	2005 ^{Year}	9:15 P M
	Examin	er	4a. Facility Name (If not						_	, or Location of Deat	th	4	c. County of Death	
H			Washingt 5. Social Security Numb				ital In yrs. last birtl	hdav)	Tak	oma Park	8. Date of	Birth	Montgome 9 Birth	ery plece (State or Foreign
	Funeral Director		196-12-529	4.0	XM 2□F		-	rs.	Months Day	s Hours Min.	Feb	Day, Yea.) Cou	ntry) Cginia
	р ,		Usual Residence of Dec			1	0c. City, Town							
	show	2		b. County			oc. City, Town	or Loc		.11				10d. Inside City Limits 1 ♣Yes 2 ☐ No
	the N	Director	MD P	rince G	eorges				10f. Zip Code	sville		10a C	itizen of What Cou	
	3a or	Ö	2600 Quee		o1 Poo	a # 9	203			20782		3.	U.S.A.	,
	death	Funeral	11. Marital Status	ilis Cliap	12. Was Dec	edent Ev		13. W	as Decedent o	f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or	No-	14. Race - Amer	
2	after or Ite		1 Never Married	_	1 Yes. G	2 No	12/42		Yes 252 N		to rican, etc.)		Black, White Specify:	31ack
3	s filed within 72 hours after death with the Maryland I Hygiene. other than "natural", or flems 23a or 28a-f show vent, I're Medical Exeminer must be notified at	d by	3 ☐ Widowed 4 🛭		Year or I	Dates:	09/49	}				105		
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7 7	filed withi Hygiene. other than ent, tre M	Completed	Elementary/Seconda 12	ry (0-12)	College	(1-4or 5+)			ice Off			L	aw Enford	cement
מומ	be filed tal Hyg d othe event,	BeC	17. Father's Name (Firs	st, Middle, Last)						18. Mother's Na	me (First, Mid	dle, Maide	n Sumame)	
<u>8</u>	should be nd Mental marked o	2		Andrew		e					usan Ma			
	i 2 sho h and 7 is m rraum		19a. Informant's Name							et and Number or R				p Code)
ָם ב	is 1 and 2 should be filed withing Hogline. If Health and Mental Hygiene. Item 27 is marked other than other traumatic event, If a.M.		Helen M. 20a. Method of Disposit		- Cous	ın	20b. Place of	Dispos	ition (Name of		Riverto Date	_	U8() / / Location - City or T	own, State
2	Pages nent of int: If it iry or o		1 ☑ Burial 2 □ C			State	۱ <u> </u>		atory or other p oln Cem		13/05		entwood,	
palitimo	그 문원 중 .		21. Signature of Funera				1016 1			dress of Facility Fo				
Ŏ	Depared Impo									densburg			od MD 20	
			23a. Part1. Enter the d shock, or heart fa	lisease, or comp ilure. List only o	olications that one cause on	caused the	ne death. Do n	ot ente	r the mode of o	tying, such as cardia	c or respirator	y arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	al	a R	4SY	pirat	or	a F	ailun	e			Onset and Death
	/Medical Examiner		resulting in dealiny		Due to	(or as in	onsequence	of):	cert	on trin				
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	outed Id ansit	Examiner	Cause (Disease or inju	ry T	D	eco	mpl	M5	ate	1 CH	F			
Š	e exectian an		resulting in death) Last	•	Due to	(or as a	conseq ence	of):		.o- 3.0 01	Vil.			
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o X O	Ξ ⊘ α		IF FEMALE:		23c. If yes, o	utcome of	pregnancy						23d. Date of deliv	10.0 7
n	n requires that the death certifit been signed by the attending t should be detached for use as	Physician/M	23b. Was decedent pre in the past 12 mon 1 ☐ Yes 2 ☐ No	nths?	1□Live	birth 2	Fetal death		Ectopic pregna Other (specify)]	Month	Day Year
j.	that the c ed by the detached	hysi	9 Unknown		9□ Unk	nown								
ν S	gned gned	by P	Part II. Other significar	nt conditions co	ontributing to	death but	not resulting in	the un	derlying cause	given in Part I.			0/	the cause of death?
ecoras	law requires as been sign 2 should be										1	Yes	2 No 3 DPro	bably 4 Unknown
e Ç	e law has b	Completed									a	Vas an utopsy erformed?		opsy findings available ompletion of cause of
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Vital	Physician: The law this certificate has b ral director, page 2 s	o Be	25. Was case referred examiner?		Hospital:	An atient	2 DER/Out	tnationt	3□ DOA	26. Place of De			6 ☐Other (Spec	(4.1)
0	Phy this rald	-	27. Magner of Death		28a. Date	e of Injury	28b. T	ime of	and the second second	njury at Vork?			ury occurred	(y)
0	Attending For death. ector: After by the funer.	atio	2 Accident	Pending investigation		nui, Day	16ar) II	ijury		☐Yes 2☐No				
DIVISION	r Atter de irecto	Certification;	3 ☐ Suicide 6 4 ☐ Homicide	G Could not be determined	289. Plat	e of Injunding, etc.	y - At home, fai (Specify)	rm, stre	et, factory, office	се	28f. Location City or	n (Street Town, Sta	and Number or Ru ite)	al Route Number,
¬	Hospital or 24 hours afte Funeral Dir itely filled in		29a. Certifier 1	Continue Bh	voicion. To th		and the endeded	doath	a a sum of at the	- Non- data and plan	d and due to	the enue	(a) and manner as	wated
	_ ~	edical	(Check only 2	Medical Exam	niner: On the	basis of e	xamination and	d/or inv	estigation, in m	e time, date and place ny opinion, death occ	curred at the tir	ne, date a	nd place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title	e of certifier	1.01	- /1			29c. Lice	ense number	.	29d. [ate signed (Month	, Day, Year)
	7)	160	JAY.	76				D454	+1		1-6-	から
/	0		30. Name and address	of person who	completed car	use of dea	ath (Item 23a) (Type, I	Print)	w.Lon	Ad112	ah c	it Ho	Soilal
	Sta	te	31. Date filed (Month),	Day, Year) (32.	Registrar	's Signature	L.	weren!	170//	Alnna	1117	11 11 100	7170
	Registi		U f	ALK IZ	LUUJ	Sales Sales	But Just	19						

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Vernon Eugene Frantz 2005 182-1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL 8. Date of Birth (Month, Day, Aug. 29 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Days 218 16 4861 1 1 M M 2 □ F Ĩ924 Director 80 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or itama 23a or 28a-f ahow event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Severn Anne Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S. 7881 West B & A Road 21144 death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 and 2 should be filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ð 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental (not available) Frantz Frida (not available) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 Carolyn Jeffrey 7881 West B & A Road Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Important: If it any injury or o once. 1

Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 4/11/2005 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature-of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 Thrang or plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the dise shock, or heart failure. List on Approximate Interval Between Onset and Death one cause on each line Immediate Cause (Final disease or condition **Physician** renmonit resulting in death) /Medical to (or as a consequence of) Examiner wosessis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been signated by page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 1 Yes 2 🗆 No Fo the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No Other: ٩ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) SIL funeral 28d. Describe how injury occurred 27. Manner of Deal 28b. Time of Certification: Alter Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dues my 31. Date filed (Month, Day, Year) 32. Segistrar's Signature APR 12 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MANDA

		, FOI	partment of Health and Nertificate of Death	Mental Hyg	•	12342
Physici /Medi		1. Decedent's Name (First, Middle, Last) CHARLES A. GUIDICE		2. Date of Deat Month APRIL O	08 2005 Year	3. Time of Death 4:45A
Examir Funeral	ner	4a. Facility Name (If not institution, give street and number) GENESIS ELDERCARE TRUCKHOUSE ROAD 5. Social Security Number 6. Sex, 7. Age (In yrs. last birthold) 212-05-2170 18/ M 2 F 97 yrs.	Months Days Hours Min	8. Date of Birth (Month, Day, June 15	4c. County of Deal	
Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	June 15	,1907 Ma	10d. Inside City Limits
with the Mar a or 28a-fs Le notified	Funeral Director	Maryland Anne Arundel Pasa 10e. Street and Number 1875 Poplar Ridge Road	dena 10f. Zip Code 21122	11	0g. Citizen of What Co	1 ☐ Yes 2 🗹 No untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deptriment of Heath and Mental Hygiene. Deptriment of Heath and Mental Hygiene. Important: If item 27 Is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumatic event, Ite Medical Eracit of must be notified at once.	by Funeral		3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 [No Specify:	pecify Yes or No- Prican, etc.)	14. Race - Ame Black, Whit	
within 72 hou ane. then "nature	Completed	15 Decedent's Education 16a De	cedent's Usual Occupation ive kind of work done during most of work a. DO NOT use retired) Supervisor	ting	16b. Kind of Business Seagrams D	
ould be filed Mental Hygid arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) James Guidice	18. Mother's Nam	e (First, Middle, M Ringl	Maiden Sumame) .eb	
t and 2 shu Health and em 27 ls m		Dennis E. Guidice (Son) 187	ailing Address (Street and Number or Rur 75 Poplar Ridge Roa sposition (Name of	d, Pasad		and 21122
uit. Pages urtment of ortant: If it ortant: Or o		Mai Dungi 5 Clemation 2 Demoval nom 2/4/6	22. Name and Address of Facility	1-05 B	Baltimore,	
perming perming part in programme any line programme any line programme any line programme any line programme any line programme any line programme any line programme and line programm	1115.7	23a. P. 11. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		, Pasade	ena, Maryla	nd 21122 Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Due to (or as a consequent of): Sequentially list conditions.	Embolism aillation			24 ms
te be executed ysician and he burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (order a consequence of):	1	_		Zyrs
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic		3 Ectopic pregnancy 5 Other (specify)		23d. Date of del Month	very Day Year
w requires that the bear signed by should be detailed.	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		pacco use contribute to	the cause of death?
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nding Physician: The lavath.	atlon; To Be	25. Was case referred to medical examiner? 1	tient 3 DOA Cther. 4 Nursing Ho		e) ence 6 Other (Spec ow injury occurred	cify)
oital or Attendurs after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town		
To the Hospital or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the tu	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, rinvestigation, in my opinion, death occur 29c. License number	red at the time, da	ate and place, and due	to the cause(s)
6		30. Name and address of pe son who completed cause of death (Item 23a) (Ty,	Doo56950 h Raynor Blud Sn	; A D	April 8th	2005
Sta Regist		NNAEMEKA Agajelu 8094 Edwi 31. Date filed (Month, Day, Year) 3 Registrar's Signature	in Kaynor 13lvd on	ile m 10	uauma n	10 21122

			For State Registrar	State of Maryla		irtment of F		d Mental Hy	gieme 0 0 5	12343
	q		Decedent's Name (First, Middle, Last)					2. Date of De	aath	3. Time of Death
	Physici /Medio		Marilyn Aimee Guil	.1				Month	Day Year	9.45PM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of D		4c. County of Dea	
			ST. AGNES	HEALTH	CARCA	BA	271	MORE	n/a	
	Funeral		Social Security Number 6. Security Number	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hours M	Hrs. 8. Date of Bir Min. (Month, Da	th 9 Bir	thplace (State or Foreign
	Director		130-20-7780 Usual Residence of Decedent	77	Yrs.				4, 1928 New	
	land		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Many -t sh	ţō	Maryland Baltimore		Catons	r: 11a				1 ☐ Yes 2X No
	r 28a	rec	10e. Street and Number		Cacons	10f. Zip Code			10g. Citizen of What Co	puntry?
	h with	Funeral Director	3 Bristol Hill Cou	rt Ant 2A		21228				d States
	death	ner	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	U.S. 13. V	Vas Decedent of H	lispanic Origin	? (Specify Yes or No	- 14. Race - Ame	erican Indian,
9	or Its	F	1 Never Married 2 Married	1 ☐ Yes 2 XNo ff Yes, Give		Yes, specify Cubi	Specify:	derto Ricari, etc.)	Black, White	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. that than "natural", or Itams 23a or 28a-f show int, the Madical Examinar must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:			эрвену.		Specify: Whi	.te
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12	withir ene. then he M	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retire	•		Hospi	tal
d 2	filed with Hygiene. other ther	ပ္	17. Father's Name (First, Middle, Last)		Lab.	<u> Pechnicia</u>	1	Name (First, Middle	<u> </u>	
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ary	should and Men is marka aumatic	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street			er, City or Town, State, 2	Zip Code)
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Baltimore,	of He of He Itam		20a. Method of Disposition		Place of Dispos			Date	20c. Location - City or	
E	Pages nent of thint: If Its int: If Its		1 XBurial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		-	Cemeters	. !	16/2005		> 000000000000000000000000000000000000
alti	permit. Pag Department Important: I any injury o		21. Signatura of Funeral Service License	90.	22.	Name and Addre	ss of Facility	Hubbard Fi	Woodlawn, I uneral Home	Tno
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г			23a. Part1. Enter the disease, or compleshock, or heart failure. List only be	cations that caused the dea	th. Do not ente	r the mode of dyir	ng, such as car	diac or respiratory a	rrest,	Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a conse		C PO				12247
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	pe #s	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quanta uty.					
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8760,	cate be executed physician and the burial-transit	E	, , , , , , , , , , , , , , , , , , , ,	Due to (or as a conse	quence or):					
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9 X	death certific e attending p id for use as	Physician/Me	IF FEMALE:	3c. If yes, outcome of pregr	ancy	73.				
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o.		ysle	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown	30	Other (specify)				
٦.	de ed		Part II. Other significant conditions cor	tributing to death but not re	sulting in the un	dertying cause giv	en in Part I.	23e. Did t	obacco use contribute to	the cause of death?
ds	uires n sign lid be	d by						10	Yes 2 No 3 Pr	obably 4 dunknown
Vital Records,	w requir	Completed						24a. Was	an 24h Were au	toney findings available
Re	The lav	шc						autorperfo	rmed death?	topsy findings available completion of cause of
		Ö	25. Was case referred to medical				26 Plans of	1 Yes		20 No
	Physician: this certific ral director,	0 8	axaminer?	lospital: 1 patient 2	ER/Outpatient	3□ DOA Oth	or.	Death (Check only o	dence 6 □Other (Spec	niée)
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ior	불극돌호	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 □	k? Yes 2 □ No			
Division	or Attandatter deatt Diractor: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of fnjury - At h	nome, farm, stre	et, factory, office		28f. Location (S City or Tov	Street and Number or Ru	ral Route Number,
Ö	ital or A rs after al Dirac led in by	Cer		Building, etc. (Opec				Only of 100	vii, State)	
	To the Hospital or A within 24 hours after To the Funaral Dirac completely filled in by	Medical	29a. Certifier Certifying Physical Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the tin estigation, in my o	ne, date and pl pinion, death o	ace, and due to the courred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Month	n, Day, Year)
	- > + 5		somme!	m D		PIT	70	-0	ADRIA CIS	3 7005
7	h		30. Name and address of person who co	mpleted cause of death (Ita	m 23a) (Type 5	Print)	9 7 7		71012,00	1, 2005
			Emmanuel C	mpleted cause of death (Ite Sei - Born 32. Registrary Sign 2 2005	zah c	low Co	aton	Ave.	Ballin.	me 21729
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's sign	ature	1.1	4		2009 1110	, , , , ,
	Registr	ar	APR 1	2 2005 Here	w K	Colore				

GUILL, MARILYN A

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death ^D2^y0 05 APRIL 3, Year Physician 17:50 PM MARY AGNES GRANINGER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** MONTGOMERY SUBURBAN HOSPITAL BETHESDA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) | 4 U.G. 29, 1928 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** WASHINGTON. 1□M 2☑F 76 Yrs 578-34-8114 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or items 23s or 28s-f show primer, ust be notified at PRINCE GEORGE LAUREL YOYes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 6212 GOODMAN ROAD IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ir than "natural", or items the Medical Exercities filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2V☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE ð 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Made (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER 1 +17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HARRY C. COFFMAN. SR. AGNES MARY DOWNEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6212 GOODMAN ROAD, LAUREL, MARYLAND 20707 TIM GRANINGER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State GATE OF HEAVEN 4/7/2005 SILVER SPRING, MD ` 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLECK FUNERAL HOME. INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707 rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sauce (Final disease or condition resulting in death) Physician SEPSIS WEEKS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying 2 WEEKS PERFORATION OF RIGHT COLON Examiner attending physician and I for use as the burial-transit CARCINOMA OF RIGHT COLON that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) page 2 should be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown RESPIRATORY_FAILURE Completed PANCYTOPENIA 24a. Was an autopsy performed?
1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 Yes 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury Division 1X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 29a. Certifie 🔭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie APRIL 5, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6410 ROCKLEDGE DRIVE, BETHESDA, MARYLAND ERNEST D. HANOWELL egistrar's Signature 31. Date filed (Month, Day, Year) State APR 1 2 2005 Registrar

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F			glene)5	12345
			Decedent's Name (First, Middle, La	st)				2. Date of De	ath		3. Time of Death
	Physici		Lorena Geral	dine	Garriso	n		April	7 20	05	12:30 A M
	/Medic Examir		4a. Facility Name (If not institution, giv	e street and number)			r Location of Deat	1	4c. Count		12.30 11
1	LXumi	101	424 Annabel Ave	enue		Brook1					City
	Funeral		5. Social Security Number 6. S	ex 7. Ac	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs				place (State or Foreign
н	Director		169-30-7381	☐M 2ÅF	67 Yrs.	Months Days	Hours Min.	Mar 27	y, Year) 1938	Cou	WV
	σ		Usual Residence of Decedent					, , , , , , , , , , , , , , , , , , , ,	,		
	nylan how		10a. State 10b. County		10c. City, Town or Le	ocation					10d. Inside City Limits
	e Ma	cto	MD Baltimo	re City		Brook	klyn				1 XYes 2 ☐ No
	or 28)Ire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	23a	a	424 Annabel Ave	nue			21225			U	SA
	r dea	iner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No	- 14. Ra	ce - Ameri	can Indian,
98	or it	F	1 Never Married Married	1 ☐ Yes 2X If Yes, Give	No	1 ☐ Yes 2 No	Specity:		Specia		θιc.
8	ural',	q p	3 Widowed 4 Divorced	Year or Dates:					Specia	y	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28e-f ehow to Medical Exerciter mat Le rotified at	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	dent's Usual Occup	during most of wo	rking	16b. Kind of B	usiness/In	dustry
12	within ne. han	mp	Elementary/Secondary (0-12)	College (1-4or	5+) <i>life.</i>	DO NOT use retired	•				
	iled v tygie ther t	ပိ	12 17. Father's Name (First, Middle, Last,			Homen		ne (First, Middle,)wn H	ome
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3	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", or eurnatic event, If a Medical Exa	To	Harold Day Gotsc		140, 44 :0			Miller			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Heatth and Mental Hygiene. If ifem 27 is marked other than "natural", or iteme 23a or 28e-1 show or other treumatic event, II o Medical Examiner must be notified at		19a. Informant's Name/Relationship (ng Address (Street					
	1 and 1ealth em 27 ther tr		Mr. Charles E. Ga	rrison / h	nusband 20b. Place of Dispo	424 Ar	nabel Av	e, Broo	oklyn, N 20c. Location		
0	Pages nent of It int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐		cemetery, cre	matory or other place					
ţ	artmen ortant: injury		`4 □Donation 5 □ Other (Specif			11 Cemete		/2005			Park, MD
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 eny injury or other tr. 2002e.		21. Signature of Funeral Service Licer	ISOO	2	2. Name and Addres	•				ome, P.A.
	au z • a		Marke 1	meure	MO1357		cond Ave			nie, l	MD 21061
7 2	Physician /Medical Examiner		23a. Part1. Efter the disease, or com shock, or neart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	etastatics a consequence of):	Col	o recta	Can			Approximate Interval Between Osset and Death Morth
.0,	cate be executed shysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last	c	a consequence of):						
8760,	ate be	dlcal	•	d					-,		
P.O. Box 68	ath certific trending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy	,			te of delive	ery Day Year
Records, P	uires thet the de signed by the a d be detached f	by	Part II. Other significant conditions of	ontributing to death b	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did to		Iribule to th	ne cause of death?
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of \	Physician: this certific	P	1 Yes 25 No	Hospital: 1 ☐ Inpatie			4 LI Nursing F	lome 5 Resid			y)
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sio	death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 ☐ No				
Division of	itel or At rs after d el Direc(Certification:	4 Homicide determined	28e. Place of In building, e	jury - At home, farm, str tc. (Specify)	reet, factory, office		28f. Location (S City or Tox		er or Rura	il Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	of my knowledge, deat of examination and/or in ated.	h occurred at the tim vestigation, in my of	ne, date and place pinion, death occu	, and due to the cred at the time,	cause(s) and madate and place,	anner as s and due to	tated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License	e number		29d. Date signe	d (Month,	Day, Year)
,	6		la ot	mi Veder	1)	04	6118		Abril	7	2005
6)		30. Name and address of person who	completed cause of o	death (Item 23a) (Type,	Print)			11	,	
No.)		JANET COOP	ER MO	1447 \	YOUK RO	of he	thervi	110	140	21093
£	Sta Registr		31. Date filed (Month, Day, Year)	32 Registr	rar's Signature	ast i					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^D2005 APRIL 8, Year **Physician** 10:47 A M GARFINKLE IRVING /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE BALTIMORE 1 POMONA EAST #202 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 11/30/1923 9. Birthplace (State or Foreign Country) 6. Sex 1 X M 2 ☐ F 7. Age (In vrs. last birthday, 5. Social Security Number **Funeral** TX 81 Yrs. 161-24-4708 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State or 28a-f show treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21208 1 POMONA EAST APT. 202 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Menial Hygiene. Importent: if item 27 is marked other then "naturel", or items 23a any injury or other treumetic event, If a Medical Exp. if are marked once. Completed by Funeral 12. Was Decedent Ever in U.S. Anned Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BALTIMORE SUNPAPER ADVERTISING SALESPERSON 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be GOLDSTRUCKER GARFINKLE BEATRICE T IRVING ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5622 GREENSPRING AVE. BALTIMORE, MD 21209 FRANZ / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 04/10/2005 BALTIMORE, MD CHIZUK AMUNO CONG. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Mesothelioma Metastatic SIX YEARS Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed as the burial-transit attending physician and Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certifica stelly filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🔀 No 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide hin 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier the within 7 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler 2 KES-000 April 08 2005 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401 North Broadway Baltimore Maryland 21231 Tanyanika P. Keine 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

2005

HOLLEY

HENRY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 4 PRIL **Physician** 9:35P M 2005 /Medical 4b. City, Town, or Location of Death

DACTIMORE 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 F 9. Bighplace (State or Foreign Spuntry) **Funeral** Yrs. Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene. em 27 is marked other then "neturel", or Items 23e or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or then "neturel", or Items 23e or 28a-f show the Medical Examinar must be nutitied at BALTIMORE 1 Yes 2 No **Funeral Director** MD10e Street and Number 10g. Citizen of What Country ROSS 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: BLACK Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

DRIVER 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0.12) College (1-4or 5+) TRANSPORTATION 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) SOUTHERN CROSS DRIVE BALTO, MD 21207 mportent: If item 27 to RETON, 20a. Method of Disposition jo 1 Burial 2 Cremation 3 Removal from State BACTIMIKE, MAKULAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CREMATION SERVICES 21. Signature of Funeral Service Licenses BAUTIMORE NATIONAL PIKE BACTO, MO 21229 / when 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician X4C weeks /Medical Due to (or as a consequence of): Examiner esp. rator weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as consequence of) Examine burial-transit Luceks neuman that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ 150 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed disor din 2PINO 2 □ No 1 Yes 1 Tyes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 QOther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yes 2 No funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No To the Hospitel or Attendil within 24 hours after death. To the Funerel Director: A 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie 🔂 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29h Signature and title-of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of d and (Item 23a) (Type, Print) 30. Name and address of person Baltz. and

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Amc

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

			For State Registrar	State of Maryland / I	Department of I Certificate of			iene g. kra. 005	12350
			Decedent's Name (First, Middle, Last)				2. Date of Death	1	3. Time of Death
	Physici		ROLAND	HARRYMAN			APRIL	8 2cos	9:06 PM
}	/Medic Examin		4a. Facility Name (If not institution, give s	reet and number)	4b. City, Town,	or Location of Death		4c. County of Dea	
			GILLEHRIST	Hospice	T	Suson		BAL	TIMORE
	Funeral		Social Security Number 6. Sex		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign
	Director		333.39-8393	W20F 79	Yrs.	7.00.0		1925	1W).
	pur 🛊		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or Location				10d. Inside City Limits
	sho	2			CARNEY				1 □ Yes 2 No
	28a-1	Director	10e. Street and Number	More	10f. Zip Code		1/	og. Citizen of What Co	ountry?
	with	급	4 1.	ve.	101. Zip 3000	21234		U. 5	
	72 hours after deeth with the Maryland natural', or Itama 23s or 28s-f show dical Examinat must be notified at	Funeral		2. Was Decedent Ever in U.S.	13. Was Decedent of	Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	***
10	r itan	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1. PYes 2 □ No 11 5.	If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	Black, Whi	
21215-0036	urs a	by	Widowed 4 □ Divorced	If Yes, Give Year or Dates: NAVI	1 Yes 22 No	Specify:		Specify: U	shite
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	filed with Hygiene. Ither ther	S	13+1	2/4	Paper cu			Paper	CORY.
<u>n</u>		Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, A	Maiden Sumame) , l	
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	s 1 and 2 f Health itam 27 l		BARBAFA Jew. 20a. Method of Disposition		3036 ⊋ № of Disposition (Name of	Ave.	Date	20c. Location - City or	
ية	0 0 == =		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	ery, crematory or other pla	1 4 1	1		
Baltimore,	5 2 3		*4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service License		12 Name and Addr		11/05	Balto W.	
Ba	permit. Deportr Importe any nju		1 Var. 9 m. 57	410.	HARTILY A		Bille Mo	21234	CITIV.
100			3a. Part1. Enter the disease, or complic	eations that caused the death. Do					Approximate
	Dharistan		shock, or heart failure. List only on Immediate Cause (Final			. 4	1		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to ir as a consequence	entic C	MYCE	V		men jus
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8760,	cate be executed physicien and the burial-transit	dlcal	d						
9		Mec	IF FEMALE:						
Вох	eath certifi attending I for use as	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal deat		у		23d. Date of de Month	livery Day Year
o.	at the de by the a tached	Physiclan/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)				
<u>α</u>	The law requires that the death certifi the has been signed by the attending tage 2 should be detached for use as		Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause g	ven in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
Records,	sign d be	d by	KOVEN Ary	greeny dise,	950		1 □ Ye	s 2 No 3 □ P	robably 4 Unknown
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Vital			25. Was case referred to medical			26 Place of Dec	1 ☐ Yes 2 ath (Check only one		2 □ No
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of	ding Phy h. After this funeral c		27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Inju		28d. Describe ho		11 /
ioi	ath. r: Aft	atlo	Natural 5 Pending 2 Accident investigation	(Month, Day 16ar)		Yes 2 No			
Division	ar dei racto by th	tifle	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, office		28f. Location (Str City or Town	reet and Number or R . State)	ural Route Number,
۵	itaio irs aft ral Di led in	Certification:							
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Madical Examin	ician: To the best of my knowledger: On the basis of examination a and manner stated.	e, death occurred at the t nd/or investigation, in my	ime, date and place opinion, death occu	e, and due to the ca arred at the time, da	use(s) and manner a ate and place, and du	s stated. e to the cause(s)
	o the o tha omple	Mec	29b. Signature and title of certifier	// /	29c. Licen	se number	29	d. Date signed (Mon	h, Day, Year)
	⊢ ≯ ⊢ ŏ		All thath	- llile	ma Di	25205	- /	April 9	2005
	20		30. Name and address of person who co	propleted cause of death (Nem 23a)	(Type, Print)	-0 0		1	2005
	1		W. A Riley	A A / /	6701 Al.	Prarles	St. ba	eto md	2120%
	Sta		31. Date filed (Month, Day, Year)	32. Degistrar's Signature	Luke				

9106 PM

Haril 8,2005

HARRYMAN Roland

amend item#10e,18 Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** CHRISTA JANE HOLLMAN April 2005 8:45 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pickersgill Retirement Community Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 200F Months Director 030-14-2195 18,1921 Germany Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont If item 27 Is marked other then "neturel", or Itams 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumetic event, the Mudical Exemples must be notified at Be Completed by Funeral Director Baltimore 1 ☐ Yes 🏋 No Maryland Towson 10e. Street and Number Chestnut 10f. Zip Code 10g. Citizen of What Country? 615 Chesnut Ave. 21204 U.S.A, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐Yes ŽŽNo Yes, Give XXNever Married 2☐ Married Maryland 21215-0036 1 ☐ Yes XX No Specify: 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Private School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Uknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meredith Boren (Friend&PR) 508 Limerick Circle Timonium, Maryland 21093 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or permit. Page Department of Importent: If eny injury or once. 4 □ Donation 5 □ Other (Specify) Greenmount Crematory 4/11/05 - Baltimore, Maryland 21. Signature of Funeral Service Licent Mitcheff-wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dreast **Physician** met menths /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 No 1 ☐ Yes ours after death.

nerel Director: After this certifica filled in by the funeral director. I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗍 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel (To the Hospital 29a. Certifier TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number us completed cause of death (Item 23a) (Type, Print) and address of pe Baltz nd 21 arles St. 6701 BITC 31. Date filed (Month, Day, Year) 32. Registrar's State 2005 Registrar

			1- State of Maryland / Depar Registrar Certification	tment of Health and M ificate of Death		ene 005	12352
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		Young Nam Han		Month	Day Year	50615 AM
	Examin			4b. City, Town, or Location of Death		4c. County of Dea	th
			3007 Louise Avenue	Baltimore		N/A	
	Funeral Director			If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 1 April 20	^{9. Bi} 0,1917 Ko	thplace (State or Foreign ountry) Yea
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	ation			10d. Inside City Limits
	daryik f sho	ō	MD BAITHARS				1 Yes 2 No
	28a-	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What C	ountry?
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3	should be filed within 72 hours after death with the Maryland not Mental Hygiene. Ind Mental Hygiene. Innerted other than "natural", or items 23a or 28a-f show umatic event, the Medical Examinating to rediffice at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 ₩ No	Yes 2 No Specify:	rican, etc.)		IANKOREAN
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5	Heal Heal tam 2		20a Method of Disposition 20b, Place of Disposit	ion (Name of D		Oc. Location - City or	Town, State
2	Pages 1 and 2 lent of Health a nt: if itam 27 is iry or othar tra		1 Buriai 2 Literemation 3 Hemoval from State	natory Inc. 04/1	1/05 B	altimore,	Marvland
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final	_ 1/	1 13		Interval Between Onset and Death
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	To the Hospital or Attanding Physician: The law requires that the death certiful 24 hours after death. After this certificate has been signed by the attending to the functal Diractor: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investigation and manner stated.	ccurred at the time, date and place, a stigation, in my opinion, death occurre	and due to the cau ad at the time, date	se(s) and manner as e and place, and due	s stated. to the cause(s)
	withii Comp	Ž	29b. Signature and title of certifier	29c. License number	290 A	Date signed (Mont	h, Day, Year)
	1)		30 Name and address of person who completed cause of death (Item 23a) (Type, Pri	Rd Surte 22;	Bal	tr. 212	(0
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			1 - For State Registrar	State of M	larylan		artment of F		nd Mental Hy	giene () (12353
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	/Medic		Audley Will						Apri1	5, 200	5 5:30 A M
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	b		30. Name and address of person what Alan R. Segal				Print) e, Silve	Sprin	ng. MD 20	0906	
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			For State Registrar	State of M	arylan		artmen <i>rtificat</i>					giene (05	12354
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8760,	cate be executed physician and the burial-transit	dicai		_ d										
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Вох	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic pre						Date of deliver	ery Day Year
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-	To the Hospital or Att within 24 hours after of To the Funerel Direct completely filled in by	Medicai	(Check only 2 Medical Examone)	miner: On the basis of and manner sta	examinat	ion and/or inv	estigation,	in my opi	nion, deat	h occurre	d at the time, d	ate and place	, and due to	the cause(s)
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	/		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type, I	Print)	rn 1	7-0	rnal.		600 N.	WOLFE	STREET
1	-01	1	CRISTINE BERRY, M.D. 31. Date filed (Month, Day, Year)						, 2047	06.2	LOUNCE.	BALTIMO	RE, ME	21287
	Sta Registr	-	APR 1	2 2005	John	ture #	Am	W						

Heisey, Bettie 4/12/05 6:20 Am

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 2005 Bettie Lou Heisey 6:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice of Baltimore Gilchrist Ctr. Baltimore Towson 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign
Country) 1 □ M 2 🕅 F Months Days Hours Min. Director 213-30-7141 72 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehov other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 4 Belmullet Court 21093 or Items 23e USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married X Married Maryland 21215-0036 1 ☐ Yes 2 💢 No þ Specify: Specify: White 3 Widowed 4 Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be ment of Health and Menta Norman Carr Wood Naomi Adeline Ravme 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas R. Heisey, Sr./husband 4 Belmullet Court; Lutherville, MD 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State perm t. Pages Department of Importent: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State All Saints Cemetery 4/15/05 4 ☐Donation ↑5 ☐ Other (Specify) Reisterstown, MD 21. Signature of Fur eral Service License 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Organic Grain Syndrome numbus /Medical Due to (r as a consequence of): **Examiner** brudst CON COR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 TYAS Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 ☐ Yes 2 🗖 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director: / 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 58303 $\sim\sim$ Jast 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)/) St Baltwore ND 2/204 hances WO (d00) 31. Date filed (Month, Day, Year) 32. Registrar's S State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

			1- For State of Maryland / Dep	artment of Health and Mertificate of Death		iene	5	23	56
	0.		Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3.	Time of I	Death
	Physici		Francis Chapman Hall, III		April 8		ear	:00	ΡМ
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	APITI O	4c. County of I		• 00	
1	Lamin	ICI	Broadmead	Cockeysville					
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth		altimo		Faraian
	Funeral Director		215-16-9237 1∑M 2□F 83 Yrs.	Months Days Hours Min.	(Month, Day,	Year)	. Birthplace Country)	(State or	Foreign
		ļ	Usual Residence of Decedent		Feb. 14	, 1922	MD		
	land w		10a. State 10b. County 10c. City, Town or L	ocation			10d. lr	nside City	v Limits
	Marylan f show	٥	MD Baltimore Spark				1	l∐Yes	2 X No
	or 28e-f	Director	10e. Street and Number	10f. Zip Code		0.000			
	with	급		Tur. Zip Code	1	0g. Citizen of Wha	it Country?		
	ath 8 23	Funeral	14737 Thornton Mill Road	21152			USA		
	e de la de	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American In White, etc.	ndian,	
36	or I	Ϋ́Ε	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No	1 ☐ Yes 2 ANo Specify:		Specify: V			
8	rel'	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			оросиу.			
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-1 show he Madical Examiner mast be notified at	Completed	(Specify only highest grade completed) (Giv.	edent's Usual Occupation a kind of work done during most of work	ing	16b. Kind of Busin	ess/industry	у	
7	ithin	ldu	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)					
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Б	be filed within 72 hours after death with the Maryla ital Hygiene. id other then "naturel", or Items 23e or 28e-f show event, The Medical Examiner must be and lifted at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, A	faiden Sumame)			
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other then " treumetic event, the Mas	ပို	Francis Chapman Hall	Margare	et Dorse	У			
ar	sho sand h		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rura	al Route Number,	City or Town, Sta	ite, Zip Code	(e)	
	~ = ~ ·		Ellen H. Hall/Wife 1473	7 Thornton Mill Ro	oad Spar	rks, MD 2	21152		
Baltimore,	ges 1 and 2 should t of Health and Men if Item 27 Is marke or other treumetic		20a. Method of Disposition 20b. Place of Disp			20c. Location - City	y or Town, S	State	
20	00-		Roslev I	inited PPLLA	. 11,	4388			
⋣			Methodis	t Cemetery 2005 2. Name and Address of Facility)	Sparl	ks, MI)	
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			MICHAEL J. Flagle	O W. Padonia Road	Timoni	ım. MD 21	1093		
			23a. Path. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac o	or respiratory arre	est,	Inter	roximate rval Betw	reen
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	/Medical		resulting in death) Due to (or as a consequence of):	F	1/	,		_	
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	death certifica attending ph for use as t	Š	IF FEMALE: 23c. If yes, outcome of pregnancy			gad Dave of			
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o.	at the de by the it ached	Physician/M	1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			ŕ		
σ.	that the ed by detac	Ph	Part II. Other significant conditions contributing to death but not resulting in the		00. 0:44-5			-	.1.0
S,	res the igned be de	by	C A The significant continuous continuous to dealin but not resulting in the	underlying cause given in Part I.		acco use contribut			
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<u>a</u>		a	25. Was ase referred/to medical	26. Place Death	111111111111		165 2	NO	
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no	ding h. After funer	tlor	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	200. 2000/100 110	w injury occurred			
3	Attending in death. ector: After by the funer	ca	3 Suicide 6 Could not be		206 Lanation (Ct-		- 0 (0		
Division	or Attend after death Director: /	Certification:	determined 4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	City or Town,	eet and Number o. State)	r Hurai Houl	te Numbe	ar,
	urs a								
	Hosp 4 ho Fune ely fi	ica	29a. Certifier (Check only analysis) 2 Medical Exeminer: On the basis of examination and/or in	th occurred at the time, date and place, any estigation, in my opinion, death occurrence.	and due to the ca ed at the time, da	use(s) and manne	r as stated.	cause(s)	
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in L	Medical	and manner stated.						
	To To	2	29b. Signature and title of certifier	29c. License number	29	d. Date signed (M	onth, Day, \	Year)	
	0		Isarvara Carrolly /A	T 1 58397		4/8/2	100		
2	11		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	7 ^	1	11	211	030
In	X		BARBARA CARROLL, M.D. 1	3801 VAVE RO	1, (12	KUMBU	11/11	MI)00
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature)	Sneeles	1	1100	1.00	10	-
	Registr		APR 1 2 2005 Marin 10 1			U			

			1 - For State Registrer		artment of Health and M rtificate of Death	lental Hygien	000 16007
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not Institution, give street and	Center	4b/9ity, Town, or Location of Death	2. Date of Death Month 5	Year 3. Time of Death C. County of Death
	Funeral Director		5. Social Security Number 6. Sex 214-50-9627 1 M 2 F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea, Feb. 28, 1	9. Birthplace (State or Foreign Country) New York
	th the Marylan or 28a-f ehow e netffied at	Irector	10a. State 10b. County MD Anne Arunde 1 10e. Street and Number	10c. City, Town or Lo Glen Burn		10g. C	10d. Inside City Limits 1 ☐ Yes 2 ☒No itizen of What Country?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other then "neturel", or Itams 23a or 28a-f ehow or other treumetic event. The Medical Exantrant termilling at	by Funeral Director	Armed 1 Never Married 2 Married 1 Yes.	ecedent Ever in U.S. 13. Forces?	21061 Was Decedent of Hispanic Origin? (Spet If Yes, specify Cuban, Mexican, Puerto I □ Yes 2⊠ No Specify:	US cify Yes or No- Rican, etc.)	A 14. Race - American Indian, Black, White, etc. Specify: white
d 21215-0036	filed within 72 ho Hygiene. other then "netur ent, the Medical	e Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College 17. Father's Name (First, Middle, Last)	d) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired) Alarm/Security Systems Installation 18. Mother's Name	ng	Kind of Business/Industry urity Systems
Maryland	d 2 should be filed within h and Mental Hygiene. 7 Is marked other then treumatic event, the Me	To Be	George E. Hall 19a. Informant's Name/Relationship (Type, Print)		Evelyn And Address (Street and Number or Rura	A. Ha11 I Route Number, City	or Town, State, Zip Code)
Baltimore, I	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tru once.		Roland Ridgeway/Friend 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify) 21. Signature 1 Junes Servi Licensee	20b. Place of Dispo cometery, crei Chesapeak Center, 22	Re Cremation April 2. Name and Address of Facility	8,2005 St	ocation - City or Town, State evensville, MD Second Ave. S.W.
	Pnysician /Medical		23a. Part1. Enter the cispase, or complications that shock, or heart failure. List only one cause or immediate Cause (Final disease or condition resulting in death) Due 1	t caused the death. Do not ent n each line.	er the mode of dying, such as cardiac o	ome, P.A.	Glen Burnie, MD 2106 Approximate Interval Between Onset and Death
	The law requires that the death certificate be executed to the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit of	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to the cause of the caus	o (or as a consequence of): o (or as a consequence of): o (or as a consequence of):	E KENAL NESPINA BESITY	DISEMS	orline unknown Nilve unlumon Unknown
.O. Box 6	at the death certific by the attending p tached for use as	Physician/Me	in the past 12 months?	gnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Records, P	w requires that been signed b should be det	by	Part II. Other significant conditions contributing to	death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
		se Completed	25. Was case referred to medical		26. Place of Death	24a. Was an autopsy performed? 1 Yes 250 No.	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of	ding Phye .r After this funeral dir	ation; To B	1 ☐ Hatural 5 ☐ Pending (Mo 2 ☐ Accident investigation	npatient 2 ER/Outpatien e of Injury 28b. Time of Injury Injury	t 3 DOA Other: 4 Nursing Hom	ie 5 ☐ Residence 8d. Describe how inju	
-	spitel or ours afte terel Dir filled in i	al Certification;	29a. Certifier Certifying Physicien: To t	ce of Injury - At home, farm, streding, etc. (Specify)	a occurred at the time, date and place, a	City or Town, State	and manner as stated
	To the Hos within 24 h To the Fun completely	Medical	(Critical California) 2 Induical California Coll (18	basis of examination and/or invinner stated.	29c. License number	29d. Da	d place, and due to the cause(s) Ite signed (Month, Day, Year)
	() Sta Registr		30. Name and address of person who completed ca 31. Date filed (Month, Day, Year) 32.	use of death (Item 23a) (Type, I	Print) RUL PL. BAL	TIMON	E, MD 21205

			1 - For State Registrar	State of Maryland	/ Department of He		ntal Hygien	. U U J	12358
	Physic /Medi		1. Decedent's Name (First, Middle, Las	HARVIN		2.	Date of Death Month D	ay Year	3. Time of Death
	Examir Funeral		4a Eacility Name (If not institution, give OSEPH KICKEY 5. Social Recurity Number 658	HOSPICE VI. Age (In yrs. last	4b. City Jown, or birthday) If Under 1 Year	If Under 24 Hrs. 8.	Date of Birth	c. County of Death	place (State or Foreign
	Director		Usual Residence of Decedent	M 202F 89	Yrs. Months Days	Hours Min.	Month, Day, Year	9/65.	CAROLINA
	the Marylan 28a-f show notified at	Director	10a. State 10b. County	2 BA	own or Location HIMORE				1 Des 2 No
	death with	Funeral Dir	201 D. WASh 11. Marital Status	12. Was Decedent Ever in U.S.	101. Zip Code 212 13. Was Decedent of His If Yes, specify Cuban	3/ Spanic Origin? (Specify Mexican, Puerto Ric	U	itizen of What Cour 14. Race - Americ Black, White,	can Indian,
5-0036	hours after turel', or ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify: B	Ack
21215	2 should be filed within 72 hours and Mental Hygiene. Is marked other then "neturel; aumatic event, Ire Madical Ex.	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation 1 de completed) College (1-4or 5+)	6a. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)	tion uring most of working	16b. 1 Clé	FANING TOMES	PRIVATE
Maryland	iould be file I Mental Hy narked oth natic event	To Be (17. Father's Name (First, Middle, Last) SAMUEL (TARTER		18. Mother's Name (F	FRA	+ZIE x	
_	1 and 2 sh Health and tem 27 Is m		19a. Informant's Name/Relationship (7	DRAKE 6	19b. Mailing Address (Street ar	Rd B	alto. 1	or Town, State, Zip	207
Baltimore	uit. Pa		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License	Removal from State	etery, crematory or other place	K 4/15/	05 11/01	dann Finn:	MELLA
ä	Departing Departing Important Import		23a. Part1. Enter the disease, or compshock, or heart failure. List only of	dications that caused the death. If	1814 11.1	BROADWA	g BAL spiratory arrest,	o.md.	2/2/3 Approximate Interval Between
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a construen	renal decin				Onset and Death
V		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequen	ce of):				years
8760,	cate be executed oby sician and the burial-transit			Due to (or as a consequent	ce of):				
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of	di S	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpatient 2 ER/ 28a. Date of Injury (Month, Day Year) 281	Outpatient 3 DOA Others o. Time of Injury Work?	at 28d.	-		Hospice
Division	al or Atter s atter dea if Director id in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)		28f.	Location (Street ar City or Town, State	nd Number or Rura 9)	Route Number,
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After thi completely tilled in by the tuneral	edical	29a. Certifier	sician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, death occurred at the time and/or investigation, in my opir	, date and place, and nion, death occurred a	due to the cause(s t the time, date and) and manner as st d place, and due to	ated. the cause(s)
	To T	Σ	29b. Signature and title of certifier	2:13	29c. License r		29d. Da	te signed (Month, L	Day, Year)
•		-	30. Name and address of person who c	ompleted cause of death (Item 23)		8583	11	April 200	5
	2		150 W. LANUAGE S	or Ballimorez	, MD 21217	-4120			
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Aparles .				

			1 - State Registrar	State of M	arylano		artmen rtificat					Reg. No	UU	5	123	59
	Physici		1. Decedent's Name (First, Middle, Last) John H. Hennessey, Sr.							i	2. Date of Death Month April		7 20	Year 05	3. Time of 11:30	
	/Medio		4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death			APLII	8 4c.	County o			A · M
			413 Old Riverside Road					Baltimore				Anne Arundel				
l	Funeral Director		212 10 3143	7. Ag	ge (In yrs. la	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	8. Date of Bird March March	th Year)	922	9. Birthi Cau	olace <i>(State o</i> p <i>try)</i> lary1an	or Foreign Id
Dalitimore, Maryland 21215-0036 Dermit, Pages 1 and 2 should be filed within 72 hours after death with the Mandand	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation								10d. Inside Ci	ity Limits
	89-1 ST	ctor	Maryland Baltimore							1 🗌 Yes	2 ∑ No					
	th with the	al Directo	10e. Street and Number 413 Old Riverside Road					10f. Zip Code 10g					izen of Wi	nat Cour	ntry?	
	rs after dea I', or Items	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 1 Yes 2 1 If Yes, Give Year or Dates:)	1	Vas Deced f Yes, spec		spanic Origin, Mexican, Specify:	n? (Spec Puerto R	ify Yes or No- ican, etc.)			Amend White,		
	72 hou neture	Completed by	15. Decedent's Education 16a. Decedent's Usual Occur					l Occupa	supation 16t			16b. Ki	b. Kind of Business/Industry			
	within ane. then "	mple				kind of work done during most of working DO NOT use retired) LCE Officer				D = 1	Baltimore City					
	Hygie other ent,	e Co	17. Father's Name (First, Middle, Last)			1011				s Name (First, Middle,				ity	
2	Mental Mental srked o	To Be	Leroy	J. Henne	ssey					Muri	el G.	Wils	on			
NO.	of 2 sho th and 7 is ma treum		19a. Informant's Name/Relationship (Type Dorothy Hennessey						nd Number		Route Numbe					00=
5	s 1 and f Healt item 2 other		20a. Method of Disposition	, will	20b. Pla	ace of Dispos metery, cren				Datu					and 21	225
ים פלים	rages nent of ant: If i		1 A Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Cre	metery, cren stlawr	n <i>atory</i> or ot 1. Mem .	her place Gai	odens	4/11	/2005					D
	ermit. Separtr nporte ny inju		21. Signature of Funeral Service License	ө	/	22	. Name and	d Address	s of Facility	Gon	ice Fun	era]	Ser	vice	∍, P.A.	
	0. L = 6 0		23a. (Bart). Enter the disease or compliants of head failure list control	mullan	ule	2 40	JO1 R:	itch:	ie Hig	hway	Balt	imor	ce, M	ary]		
	nysician Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each iii	E M	YOC					7 (OA				Approximate Interval Betw Onset and D	veen
E	xaminer		Sequentially list conditions, b													
7	nsit	Examiner	Sequentially list conditions, I amy leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a GUNBIGUIA	ince of):										
	ohysician and the burial-transit	Exal	that initiated events cresulting in death) Last	Due to (or as	a conseque	ince of):								-		
-	physic the bu	dlcal	d			_	_				_			-		
IVISION OF VITAL RECORDS, P.O. BOX of Attending Physicien: The law requires that the death certificate has been sinned by the attending.	by the attending placehold for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal c	leath 3 🗌	Ectopic pre Other (spe					2	3d. Date of Month		-	ear
	ned by detac	by Ph	Part II. Other significant conditions conf	ributing to death b	ut not result	ing in the un	derlying ca	use giver	n in Part I.		23e. Did to	bacco us	se contrib	ute to th	e cause of de	ath?
	been sign	o Be Completed b								es 2[2 No 3 Probably 4 Nonknown					
	ate has b										24a. Was a autops perform	sy med?	pric	or to con th?	osy findings an npletion of car	vailable use of
	certific irector,		25. Was case referred to medical examiner?	26. Place of Death (Check only one) ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6												
	ter this neral di	\vdash	1 Yes 2 100	28b. Time of 28c. Injury a			4 Nursing Home		me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred							
	eath. or: After the funer	catlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury			Work?" M 1 ☐ Yes 2 ☐ No									
	s after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
o Lineanie	uner uner sely fill	edical (29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	cian: To the best of er: On the basis of and manner sta	examinatio	edge, death n and/or inve	occurred at estigation, i	the time	, date and p nion, death o	lace, and	due to the ca at the time, d	ause(s) a ate and p	and mann place, and	er as sta I due to	ated. the cause(s)	
Toth	within 24	Me	29b. Signature and title of certifier	1 0		A .		License					-		Day, Year)	
		İ	- Fru	-def	- 1	v(1)]	21	776		F	PRI	L 8	, 2	2005	
	6+1		30. Name and address of person who con		eath (Item 2	3a) (Type, P	rint)	2	57	RA	FIMO	RE	Mi	2(.	225	
100	Stat	e	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatui	re										

DHMH 17 Rev 1/2001

ORIGINAL

			1- State of Maryland / Department of Health and M Certificate of Death		2000 17360						
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Marion J. Howington	2. Date of Death Month	Day Year 3. Time of Death 2.1/0 A M						
	Exami		4a. Facility Name (If not institution, give street and number) Arunde HOSDITA 5. Social Security Number 6. Sex 7. Age In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs.	R Date of Birth	4c. County of Death						
	Director		216 34 4406 1 M 2 X F 67 Yrs. Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth (Month, Day,) July 30,	1937 Pennsylvania						
	ath with the Marylan 23e or 28a-1 show ust be notified at	ctor	Maryland Anne Arundel Glen Burnie		10d. Inside City Limits 1 ☐ Yes 2 ∑ No						
	with th	Directo	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Country?						
	death v	Funeral	7355 East Furnace Branch Road 21060 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	- 7 V	U.S.						
920	or Ita	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2☑ No If Yes, specify Cuban, Mexican, Puerto If Yes, Give 1 □ Yes 2☑ No Specify:	ecry Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White						
Maryland 21215-0036	rithin 72 hours nan "natural", e Medical Ext	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of worki	ing 16	b. Kind of Business/Industry						
2	be filed withital Hygiene. d other than event, the M	S	10th Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name		Own Home						
rylanc	Men Men arka	To Be	George Slater Ma	rion Legg	g						
	s 1 and 2 sho if Health and itam 27 Is m other traums		Eugina Everson / Daughter 12891 Greensboro Road	Greensbo	ro, Maryland 21639						
Baltimore,	of of		20a. Method of Disposition 1 및 Burial 2 □ Cremation 3 □ Removal from State 3 □ Other (Specify) 20b. Place of Disposition (Name of commetery, crematory or other place) Glen Haven Mem. Park 4/8/2		c. Location - City or Town, State len Burnie, Maryland						
Balti	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licensee 22. Name and Address of Facility GO	nce Funer	ral Service, P.A.						
					more, Maryland 21225						
	Pnysician /Medical		23a. Part. Enter the disease, o coordinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Approximate Interval Batween Onset and Death Due to (or as a consequer ce of):								
	Examiner	P	Albertaclocacis	12.11							
8760, ~	cate be executed ohysician and the burial-transit	dicai Examiner	Sequentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Diabetes Mellitus Type Z Due to (or as a consequence of):								
9	tificate ig phys as the	ledic	0.								
P.O. Box	that the death certifice ted by the attending ph detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year						
	v requires been sign should be	Completed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?						
900		piet	Left Hemiparesis	24a. Was an	24b. Were autopsy findings available						
of Vital Records,	nn: The ificate h	e Com	25. Was case referred to modical	autopsy performed 1 Yes 2							
Ξ	Physicien: this certifica al director,	To Be	examiner?		a Flore - 10						
ion of		ation: T	27 Magner of Death	ne 5 Aesidence 6 Other (Specify) 8d. Describe how injury occurred							
Division	I or Attendate after death Diractor:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)						
)	To the Hospitel or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, as a medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)						
	To the within 2 To tha complete	Ž	29b. Signature and title of certified 29c. License number		Date signed (Month, Day, Year)						
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-0	4-06-05						
	Sta		Richard E. Fisher, M.D. 4710 Pennington A. 31. Date filod (Morith, Day, Year) 32. Agistrar's Signature	ve. Bat	4-06-05 timore, MD 21226						
	Registra	~8	APR 1 2 2005 Brown & Spelle								

				State of Maryland / Department of Health and M 1 - State Registrer Certificate of Death		4000	12361
	V			Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	Reg. 2. Date of Death		3. Time of Death
	*	Physici /Medi		Bernard Hipkins	April 7	2005	3:45 %
	1	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	1
		Funeral		5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthr	blace (State or Foreign
	L	Director		212-38-1085 12 M 20 F 65 Yrs. Months Days Hours Min.	March 4	1940 Ma	(yland
		and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		· - · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
		Marylan Fr show	tor	Maryland N/A Baltimore			1/∆Yes 2□No
		or 28a-f	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cour	ntry?
		wurs after death with tha Maryla el', or Items 23a or 28a-f shor Examiractiquat by Lovilited at		1143 E. Northern Parkway 21239		USI	4
	(0	r items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\times \) Never Married 1 \(\times \) Yes, specify Cuban, Mexican, Puerto 1 \(\times \) Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Americ Black, White,	
	21215-0036		by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:		Specify: B	acK
	15	n 72 hours "naturel", ed red Ex	Completed	15. Decedent's Education (Specify only highest grade completed) (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	king 16b	b. Kind of Business/In	dustry
	212	d withir giene. r then	omo	Elementary/Secondary (0-12) College (1-4or 5+) SCTAD Dealey	- 01	Un Bus	siness
		be filed within 72 ho ital Hygiene. id other then "natul evant, I'm Medical	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Maid	den Surname)	2111233
	Maryland	d 2 should be filed w th and Mental Hygier 7 is markad other ti treumetic evant, II.	2	Bernard E. Hinkins Odes 19a. Informant's Name/Relationship (Type, Print) (501, 60) 19b. Mailing Address (Street and Number or Rur	ser t	Knight	
. (Ma	D = 2 1	1	19a. Informant's Name/Relationship (Type, Print) (Frother) 19b. Mailing Address (Street and Number or Rui Rev. Patrick H. Hipkins 1421 Bellona Ave	Luthe	cilile Mi	1 21192
烧	ore,	一工商量			/	. Location - City or To	own, State
347	Baltimore,	permit. Pages Deportment of I Importent: If its any njury or o		'4 Donation 5 Other (Specify) // LiOn	12005 /	ansdow	ne, Md.
)	Ball	permit. Deportr Importe any nju		21. Signatore of Funeral Service Licensee 22. Name and Address of Facility	Funeral	Home P.I	1.
6				23a. Par1/Enter the di vase, or complications that can dithe death. Do not enter the mode of dying, such as cardiac shick, or heart failure. List only one cause on each line.	or respiratory arrest,	Md. 212	Approximate Interval Between
5,	y	Physician		Immedial: Cause (Final disease or condition a			Onset and Death
0		/Medical Examiner	П	resulting in death) Due to (or as a consequence of):			Untrown
T	Ü.		e.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		-	Unkrain.
77		cuted nd ransit	Examiner	Sequentially list conditions if any, leading to immediate cause. Links Unionlying Cause (Disease or injury that initiated events			n known'
KI	90,	te be executed ysician and e burial-transit		resulting in death) Last Due to (or as a consequence of):			
7	68760	4 5 E	Completed by Physician/Medical	d			
	Box (eath certific attending p I for use as I	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delive	эгу
3		e death	sicia	1 Live birth 2 Fetal death 3 Ectopic pregnancy		Month	Day Year
F	P.0.	that the de ed by the a detached i	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the	ne cause of death?
ERNARD	Records,	quires tha n signed ald be det	d by	Hypertusier	1 ☐ Yes		
EI	000	aw require 1s been si 2 should t	plete	Diebetes Mellitus	24a. Was an	24b. Were auto	psy findings available impletion of cause of
8		The lav	Com		autopsy performed	No 1 ☐ Yes	2 No
53	Vital	sician certific rector,	Be	examiner?	h Check on one		
3	of	y Phys er this eral dir	n: To	27. Manyer of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Residence 28d. Describe how in	e 6 □Other (Specify njury occurred	y)
HPKINS	ion	ttending F death. ctor: After y the funer	atio	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
丰	Division	or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
		urs urs erel		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause	e(s) and manner as s	ated.
		To the Hosp within 24 ho To the Fund completely f	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, date	and place, and due to	the cause(s)
		To 1	×	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month,	
	1	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		4-8-2	200
	. ,) (Dalicet Salva Mo 1600 with MT Royal Ave	Balt Mr	7 21217	
		Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
		Registi	relr	APR 1 2 2005 Bearing A Comment			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 10, **Physician** 2005 6:05P M Glenn Elwood Jeffery /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Reisterstown 12333 Bonmot Place If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 24, 1954 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Sex XXM 2□F **Funeral** Maryland Director 218-60-8790 51 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show other traumatic event, if a Medical Exertitud rust be notified at 1 ☐ Yes XXNo Completed by Funeral Director Reisterstown MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 2 should be filed within 72 hours after death with to and Mental Hygiene. Is markad othar than "natural", or Itams 23a or 9 U.S.A. 21136 12333 Bonmot Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes **¾☐X**No f Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XIXNo Specify: Specify: If Yes, Give Year or Dates: 3 Widowed A Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be June Rowan Robert E. Jeffery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 nent of Health a Rose M. Day/Personal Rep. 12333Bonmot Place Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial Appremation 3 Removal from State ŏ Department of Important: If any injury or once. ` 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 4/13/05 Baltimore, MD 21. Signature Funeral Service Lices 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HEDATOCELLULAR CARCINOMA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): use as t Box (IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ ASCITES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed CHRONIC VIRAL HEPATITIS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Division Hospital or Attanding 5 Pending investigation 1 X Natural 1 Yes 2 No death. 2 Accident Diractor: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaraf I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cerumer Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier ARRIL 12 2005 D46334 · III, MO who completed cause of death (Item 23a) (Type, Print) 1. OKOLO III, MD 2435 W. BELVEDERE AVE BALTIMORE, MO ZIZIS PATRICK , SLITE 51 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2005 Registrar A Call of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#4c, perMD, G842, 414/05 II

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Apyril 8, 2005 Betty Ellen Johnson 5:30 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1325 Medfield Avenue Baltimore USA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 14, 1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-24-9115 1 □ M 2 X 78 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Nedical Eraminar must be notified at N/ABaltimore Maryland 1 Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1325 Medfield Avenue 21211 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'naturel', or items 23a any injury or other traumatic event, the Mentales E. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② X X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes ŽŽ No Specify: SpecifiWhite 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Hedrick Beulah С. Fisher 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bruce Johnson 3732 Tudor Arms Avenue Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore—Washington 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/11/2005 Laurel, Maryland ⁴ □ Donation]5 ☐ Other (Specify) Crematory 22. Name and Address of Facility Burger-Henss-Seitz Funeral Home, Inc. 3631 Falls Koad, Baltimore, Maryland Foneral Service Licensee, 21211 23a. Part I. En The disease, or complications that caused the death. shock, or wart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter University Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit s been signed by the attending physician and should be detached for use as the hurial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No certificate 1 Yes 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: P 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature andfittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 33226 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fal 1timore a 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician Jones 1630 06 2005 Louis toril /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore 7204 Diana Place If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Days Hours 225-26-Yrs. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or itams 23a or 28e-1 show traumetic avant, the Medical Everthet must be notified at 1 Yes 2 □ No Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Aispanic Origin? (Specify Yes or No-If Yes, specify Caban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BIACK Completed by 4 Divorced 3 Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DONOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If itam 27 is marked other than "na any injury or other traumetic avant, Ita Medic one. Elementary/Secondary (0-12) College (1-4or 5+) eacher VIRS 18. Mother's Name (First, Middle, Maiden Sumame) Father's Name (First, Middle, Last) Be Jones Kichard 19b. Mailing Apress (Street and Number of Fural Boute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) elores Jones 1)lana 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 VBurial 2 □ Cremation 3 □ Removal from State Not'l Memorial Cark 4-11-05 Laure M)
22. Name and Address of Facility Vaugha C Greene Funeral Services 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Kd. Kandallstown, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) of Physician Metastatic the cancer years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 1 Natural 5 Pending investigation 1 Tes 2 No death. s after death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3
Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier

Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours a To the

> State Registrar

31. Date filed (Month, Day, Year) 2005

D Roggen

29b. Signature and title of certifier

Old Court Road 32. Registrar's Signature

mo

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Sute 108

D 32844

Rundallstown

29d. Date signed (Month, Day, Year)

08

2005

21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5400

e Type of Print in Black Indelible ink. Ensure All Cop	ies Are Legible.	
State of Maryland / Department of Health and Mental	Hygiene 005	
Certificate of Death	Reg. No.	1

ر ک	120		For	State of Ma	_	•		Health and M	lental Hy	giene	005	12365
			State Registrar			Cei	tificate of	Death		Reg. No		1 6.000
ı	Physici		1. Decedent's Name (First, Middle, $John$	Edward Ko	walevi	СZ			2. Date of De Month April		2005 Year	3. Time of Death 07:12 P.M
	/Medic Examin		4a. Fecility Name (If not institution,				4b. City, Town,	or Location of Death	-	4c.	County of Death	1
ı			Franklin Square	Hospital			Rosedal	.e		E	Baltimore	e County
Ī	Funeral Director				e (In yrs. last birt 65	thday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da Sept. 2	y, Year)		pplace (State or Foreign intry) ryland
	D .		Usual Residence of Decedent		1							
	urylar show	_	10a. State 10b. County		10c. City, Towr							10d. Inside City Limits 1 ☐ Yes 2 No
	e Ma	cto	MD Balt	timore		Mic	ddle Ri	ver				
	h with th	al Directo	10e. Street and Number 1213 Sugarmi	ill Circle			10f. Zip Code 21 2	20		10g. Cit	izen of What Cou	untry?
	deat	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13.	Was Decedent of	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No		14. Race - Amer Black, White	
036	n 72 hours after death with the Marylan "natural", or Items 23a or 28a-f show polical Examiner must by motified at	þ	1 Never Married 2 Marrie 3 Widowed 4 Divorced		No		1 Tes, specify Cub 1 ☐ Yes 2 🖾 No		ricali, etc.)		SpecifyWhi	
Ş	2 ho	ted	15. Decedent's	s Education	16a.	Deced	dent's Usual Occu	pation	ing	16b. K	ind of Business/l	ndustry
Maryland 21215-0036	withir ene. then	Completed	(Specify only highest Elementary/Secondary (0-12) 6th	College (1-4or 5	⁽ⁱ⁺⁾ T		ck Driv	during most of worked) ed)	iii g	Tr	ansport	tation
ַ		Be C	17. Father's Name (First, Middle, L	ast)	,			18. Mother's Name	e (First, Middle,	Maiden	Sumame)	
<u>ā</u>		To E	John I. Kow	alevicz				Agnes	M. Web	er		
a	2 shou and h Is ma		19a. Informant's Name/Relationsh	ip (Type, Print)	19b.	. Mailir	ng Address (Stree	t and Number or Run			or Town, State, Z	ip Code)
Σ	₽ 5 15 15		Patsy M.Kowa	levicz/wi	fe '	121	3 Sugar	rmill Ci	role B	alt	imore 1	1d 21220
altimore,	es 1 g of He of He fitem roth		20a. Method of Disposition 1X Burial 2 Cremation	2 Demoval from State	20b. Place of cemeter	Dispo	sition (Name of natory or other pla	ice)	Date	20c. Lo	ocation - City or 1	own, State
Ĕ	Pages nent of I ant: If it ury or o		`4 □ Donation 5 □ Other (Sp		нотутт	cın	ityOrtr	nodex 4/	15/05	E1.	kridge	MD
Balt	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		21. Signature of Funeral Service L	icensee	lly	22	Name and Address	ess of Facility Co ce Ave.				meofEssex 221
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that caused	the death Do r	not ent					110	Approximate Interval Between
1	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a other		of):	nicou	dievaso	whor of	<u>156</u>	ease	Onset and Death
	Examiner		Sequentially list conditions.	b								
	p	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of	of):						
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of	of).						
8760,	be ex ician burial			Due to (or as	a consequence (01).						
	cate physi	dlcal		d								
O. Box 6	death certiff e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. II yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death		Ectopic pregnanc	>y			23d. Date of deliv Month	very Day Year
٦.	that ted by	h h	Part II. Other significant condition	ns contributing to death b	ut not resulting in	n the u	nderlying cause gi	ven in Part I.	23e. Did t	obacco i	use contribute to	the cause of death?
ords,	w requires that the been signed by th should be detache	ted by							10'	Yes 2	□No 3□Pro	bably 4 Unknown
n of Vital Records,	aw as b	Completed	<u> </u>							osy ormed?	death?	opsy findings available ompletion of cause of
ta		e e	25. Was case referred to medical					26. Place of Deat		2 □ No оле)	105	20140
>	d is	OB	examiner? 1 ∑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2XX ER/Ou	tpatier	it 3 DOA Ot	her: 4 Nursing Ho			6 ☐Other (Spec	ify)
0	ing Phys	on: T	27. Manner of Death	28a. Date of Inju		Time of		iry at	28d. Describe			
=	로 등 등	0	1 Natural 5 ☐ Pending	(inclini, Da)	,	10.7	14 15	7V 7 (7N-				

To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Att completely filled in by the fur Certificat Medical

2 Accident

investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 11, 2005 **OCME**

Baltimore, Maryland 21201 111 Penn Street

State Registrar 31. Date filed (Month, Day, Year)

3 Suicide

4 - Homicide

			1 - For State Registrar	State of Mary		epartment Certificate				giene Reg. No.	2005	12366	
			Decedent's Name (First, Middle, Las	it)			-		2. Date of Dea	ath	V	3. Time of Death	
	Physici /Medic		Lloyd Alfred K	raushaar					April_	Bay 8	2005	7:30A M	
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or Locati	ion of Death		4c.	County of Deal	th	
			Somerford Place	- 1			lumbia	de Od Hee			Howard		
	Funeral		5. Social Security Number 6. Se	XIM 2DE	yrs. last birtl	nday) If Under 1 Months	Days Hou	rs Min.	8. Date of Birt (Month, Day	v, Year)	Co	thplace (State or Foreign buntry)	
	Director		107-09-5027 Usual Residence of Decedent	9	Ι .				Oct. 5	, 1913	New	York	
	yland		10a. State 10b. County	10	c. City, Town	or Location						10d. Inside City Limits	
	Mar.	żo	Maryland Howard		E	llicott	City					1 ☐ Yes 21 No	
	or 28	Director	10e. Street and Number			10f. Zip (Code			10g. Citiz	en of What Co	ountry?	
	23a 23a		4205 Red Bandana				1042				.S.A.		
	er des	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was Decede	ent of Hispanic fy Cuban, Mex	: Origin? (Spe dican, Puerto I	icify Yes or No- Rican, etc.)	. 1	 Race - Ame Black, Whit 		
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 □ Divorced	1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates:		1 🗌 Yes 2	⊠ No Spec	cify:			Specify: Wh	nite	
2-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28a-f show he Medical Examiner must be notified at	led	15. Decedent's Ed	ucation	16a. I	Decedent's Usual	Occupation			16b. Kir	nd of Business/		
212	hin 7.	Completed	(Specify only highest gra	de completed) College (1-4or 5+)		(Give kind of work life. DO NOT use	retired)	most of workii	ng				
7	filed wil Hygien Sther the	Son		5+	Per	sonnel D					neral N	Motors	
2	be fill d oth	Be	17. Father's Name (First, Middle, Last)				18. M	other's Name	(First, Middle,	Maiden .	Sumame)		
<u> </u>	should not marke umatic	5	Alfred Kraushaar	r Dial	401	Martin Addison			I. Llo		T 01	7-0-10	
Maryland 2121	d 2 sk th and 7 ls n traun		19a. Informant's Name/Relationship (1) Sandra DeLaney (1)	Daughter)		Mailing Address (yland 21042	
_	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition			Disposition (Name of, crematory or other			ate		cation - City or		
altimore,	permit. Pages Department of I Important: If itt any injury or o		1 Burial 2 Cremation 3 .	Hemovai nom State		r, crematory or oth eake Cre		4-14.	-2005	Ro1+	ovillo	, Maryland	
₹	nit. Partme ortan injur		21. Signature of Funds Septice Len		Cilesap	22. Name and	Address of Fa	acility		DETL	SVIIIE	, Haryrand	
ñ	Per Per Suppose	1) Calle	- Moi2	90	Witzke 5555 Tw	Funera in Kno	l Home: 11s Ro	s, Inc ad Coi	umbi	a, Mary	land 21045	
			23a. Part1. Enter the disease, or comp	olications that caused the	death. Do n					rest,		Approximate Interval Between	
	Physician		shock, or heart (a ilure. List only one cause on each line.										
	/Medical		resulting in death) a Due to (or as a consequence of):										
	Examiner		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									3years	
	ed sit	lue	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a co	onsequence o	n):						D 45	
	xecut and al-trar	Examlner	that initiated events resulting in death) Last	c. Due to (or as a co	nsequence o	f):							
68760,	The law requires that the death certificate be executed attending physicien and bage 2 should be detached for use as the burial-transit			d.									
	ifficat g phy as the	edical											
Вох	eath certifi attending I I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		3 □Ectopic pre	gnancy			2	3d. Date of del	,	
	e dea he att	scl	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tim 9☐Unknown		5 Other (spe				10	Month	Day Year	
<u>о</u> .	w requires that the death cer been signed by the attendir should be detached for use	Phy	9 ☐ Unknown Part II. Other significant conditions c		at reculting in	the underhine ee	uaa anuaa ia B	lost I	220 Did to	phageo III	e contribute to	the cause of deeth?	
ŝ	ires the signe	b	11 0 1 = =	(A)	ot resulting in	the underlying ca	use given in F	alti.		es 2[
Š	requ been should	Completed	righeriens	(01)					24a. Was				
Rec	has ge 2	dm							autop perfo	sy mea?	prior to death?	utopsy findings available completion of cause of	
Vital Records,	sicien: Th certificate rector, pag	မ Co	25. Was case referred to medical				26 P	Place of Death	1 ☐ Yes	2 No	1 🗆 Yes	2 □ No	
5	Attending Physicien: r death. ector: After this certifica by the funeral director, I	To B	examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Out	patient 3 DO/	0.1		ne 5 ☐ Resid		Other (Spe	cifv)	
Division of	g Physier this		27. Mayiner of ath	28a. Date of Injury (Month, Day Ye	28b. T	ime of 28	c. Injury at Work?	_	28d. Describe h			,,	
0	anding F ath. or: After ne funera	atlo	1 Natural 5 Pending investigation	1		M	1 ☐ Yes 2	2 □No					
<u> </u>	l or Atten after deatl Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (3	- At home, far Specify)	m, street, factory,	office	2	28f. Location (5 City or Tox	Street and vn, State)	f Number or Ru	ural Route Number,	
	urs af												
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical		ysician: To the best of m niner: On the basis of ex and manner stated	amination and								
	within 2 To the complet	Mec	29b. Signature and title of certifier	and manifer stated	•	29c.	License numb	ber		29d. Date	signed (Mont	h, Day, Year)	
	F 3 F 8		L D	In M	D	Ī	0 58	5747	-	An	יו ור	2005	
	J1		30. Name and address of person who	completed cause of deat	n (Item 23a) (Type, Print)							
	1		Randal P P	Liesett	0700	Circute	el Di	Coli	umbig	a pl	10 S	1044	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	Signature	t. Aga							
	Registi	ar	APR 1	2 2005	die ,	A Agos							

		1	State of Maryland / Department	artment of Health and M <i>rtificate of Death</i>	lental Hygiene Reg. No.	2005 12367
H	Physicia	ın	JOSEPH B. KROPP		2. Date of Death Month Day APRIL 8	3. Time of Death 2005 1:35p ^M
	/Medic Examin		ta. Facility Name (If not institution, give street and number) 7913 33rd Street	4b. City, Town, or Location of Death ROSEDALE	BA	County of Death
	Funeral Director		5. Social Security Number 218-28-9857 6. Sex 1 M 2 F 7. Age (In yrs. last birthday, 73 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 6–12–1931	Birthplace (State or Foreign Country) MARYLAND
	filed within 72 hours after death with the Maryland Hygiene. Hygiene when the state of 28a-1 show ther then "natural", or Itams 23a or 28a-1 show ent, it is Madical Examinat must be rectified at	ctor	10a. State 10b. County 10c. City, Town or L MD BALTIMORE 10e. Street and Number	ROSEDALE 10f. Zip Code	10g. Citiz	10d. Inside City Limits 1 □ Yes 2 No zen of What Country?
	s 23a or		7913 33rd Street	21237	ecify Yes or No-	U.S.A. 14. Race - American Indian,
350	urs after de al', or Itam Xeniner	by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in 0.5. Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates: KOREAN	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 XNo Specify:		Black, White, etc. Specify: WHITE
215-0036	thin 72 hou e. an "natura Medical E	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing	nd of Business/Industry
1212 pu	e d al	Be	11 17. Father's Name (First, Middle, Last) BERNARD KROPP	SHIP YARD 18. Mother's Nam ANNA	e (First, Middle, Maiden (DOBROE	
Maryland	should and Mer a marke	To	19a. Informant's Name/Relationship (Type, Print)	ling Address (Street and Number or Rui	ral Route Number, City or	r Town, State, Zip Code)
d)	ages 1 and 2 ant of Health it: If itam 27 l y or other tra	-	20a. Method of Disposition 20b. Place of Disposition cemetery, cre			D 21220 cation City or Town, State ddle River, MD
Baltir	permit. Pages 1 Department of F Important: If its eny injury or ot once.			22. Name and Address of Facility CV		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	nter the mode of dying, such as cardiac Chromic E		Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Con		
P.O. Box 68	that the death certifica led by the attending ph detached for use as th	Physician/Medicai		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that s been signed b should be deta	δ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2	use contribute to the cause of death?
Vital Records,		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \) No
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes	Other _	ome 5 X Residence	6 □Other (Specify)
ion of	fing After fune	H	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (njury) (Month, Day Year)		28d. A scribe how injur	
Division	or At fter o Siraci in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, State	
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	irred at the time, date and	d place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number	me \$ 41	te signed (Month, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	D 31	201
		ate trar	30. Name and address of person who completed cause of death (Item 23a) (Type 10	conti		

		-	For State Registrar		State o	of Marylan	-	artment of H rtificate of				jiene leg. No.	05	12368
			1. Decedent's Name (Fir							1	2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		JAMES	SHAU	N	KERNAN		,			April	09,	2005	18:10 ^M
	Examin		4a. Facility Name (If not	institution, give	street and nu	ımber)		4b. City, Town, o				4c. 0	County of Deatl	n
			4601 New C			7. Age (In yrs.	last hirthday		altimo		R Date of Birth	1		nplace (State or Foreign
	Funeral Director		218-88-789		∑ M 2□F	1. Ago (in)13.	38 Yrs.	Months Days	Hours	Min.	B. Date of Birth (Month, Day 2-23-	1967	Ço M	ARYLAND
	D		Usual Residence of Dec											
	arylan show	_	MD 10a. State 10b	D λ T . Tr	IMORE	10c. Cit	y, Town or L		EDALE					10d. Inside City Limits 1 ☐ Yes 2 🖫 No
	28e-f	Director	10e. Street and Number		Inoid			10f. Zip Code		_		10a Citiz	en of What Co	7.7
	d within 72 hours after death with the Maryland jeene. Ir than "natural", or Items 23a or 28e-f show The Madical Examination must be notified at	I Dir		5th STR	EET			75 2	2123	7			U.S	
	death	Funeral	11. Marital Status		12. Was Dec	cedent Ever in U	.S. 13.	Was Decedent of I	Hispanic Ori	gin? (Spec	ify Yes or No-	1	4. Race - Ame Black, White	
9	or ite	F	1 Never Married		1 ☐ Yes If Yes, G	2 ሺ No ive		1 ☐ Yes 2 No		,, , , , , , , , , , , , , , , , , , , ,	, 0.0.7			HITE
21215-0036	hours tural',	d by	3 Widowed 4	Divorced Decedent's Ed	Year or I	Dates:	16a Dece	dent's Usual Occu	nation			16b Kin	d of Business/	
75	In 72 n "nat	Completed	(Specify or	nly highest gra	de completed		(Give	kind of work done DO NOT use retire	during mos	t of working	9	100. 1411	0 203003	
212	d withln giene. or than "u	mo.	Elementary/Secondar	y (0-12)	College	(1-4or 5+)]	LONG SHOP	EMAN			ATL	ANTIC T	RADING CO.
Maryland	buld be fitted Mental Hygid arked other atic event, It	Be	17. Father's Name (First	t, Middle, Last) MICH	AEL	KERNAN				er's Name (RLENE	(First, Middle,	Maiden S AUFFI		
aryl	S D E E	우	19a. Informant's Name/	Relationship (7	Type, Print)		19b. Mail	ng Address (Stree	t and Number	er or Rural	Route Numbe	r, City or	Town, State, Z	Tip Code)
	1 and 2 Health a tem 27 is		MARLENE KEI	RNAN-MI	NCHER/		7931	35th SI	REET		SEDALE		2123	<u> </u>
ore	ges 1 ar t of Hez if Item or othe		20a. Method of Dispositi 1 ☑Burial 2 ☐ Cr		Removal from	State	cemetery, cre	osition (Name of matory or other pla		Da			ation - City or	
Baltimore,	trent of thent: If It tent: If It		`4 Donation 5 □	Other (Specify	")	OAR		CEMETERY		4-15-			TIMORE	<u> </u>
Bai	permit. Pages Department of I Importent: If Its any injury or or once.		21. Signature of Funera	al Service Licer	See J		_ 2	2. Name and Address 1211 CHE					LE, MD	21237
			23a. Part1. Enter the di shock, or heart fai	isease, or compilure. List only	olications that one cause on	caused the deat each line.	th. Do not en	ter the mode of dy	ing, such as	cardiac or	respiratory arr	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Fina disease or condition resulting in death)	al	a MI	Mip	le in	jurie:	2					
	/Medical Examiner		1000ming in douin	ſ	Due to	o (or as a conseq	tuence of):)						
		ē	Sequentially list condition if any, leading to immediate	ons, diate	b. Due to	o (or as a conseq	quence of):						-	
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injurthat initiated events	ny 1	c									
o,	e exection are urial-t	EX	resulting in death) Last		Due to	o (or as a conseq	quence of):							
8760,	cate be executed physician and the burial-transit	dicai			d									
9	eath certific attending p	/Me	IF FEMALE:		23c. If yes, o	utcome of pregna	ancy					2	3d. Date of deli	iverv
Вох	atten atten I for u	Physician/Me	23b. Was decedent pre in the past 12 mon 1 ☐ Yes 2 ☐ No	nths?	1 ☐ Live	birth 2 ☐ Feta gnant at time of c	al death 3	□Ectopic pregnanc □ Other (specify) _	у			-	Month	Day Year
O.	that the de ned by the a detached t	hysi	9 Unknown		9□ Unk	nown								
S, P	The law requires that the death certifi ste has been signed by the attending l cage 2 should be detached for use as	by P	Part II. Other significan	nt conditions o	ontributing to	death but not res	sulting in the	underlying cause g	ven in Part I	l.			-	the cause of death?
örd	w require been signature										1 U Y	es 21	No 3□Pr	obably 4 Unknown
Records,	e law r has be ge 2 sh	Completed				_					24a. Was a autop	sy		topsy findings available completion of cause of
al H											1 Yes	2 □ No	1 XYes	2 No
Vital	Physician: The rthis certificete ral director, pag	Be	25. Was case referred to examiner?	to medical	Hospital:	7.12-ation 0.1	ER/Outpatie	nt 3□ DOA O	hor		(Check only or ie 5 ☐ Resid		MOther (Sec.	oital CODATE
of		T: To	1X Yes 2 No 27. Manner of Death		28a. Date	e of Injury	28b. Time	of 28c. Inju	ıry at		8d. Describe h	ow injury		SCENE SCENE
ion	Attending Ph ir death. ector: After th by the funeral	atlor	1 □Natural 5 2 ☑ Accident	Pending investigation		nth, Day Year)	18:		yk? Yes 2□	No	Grgo	TC	11 00 3	subject
Division	for Attendi after death. Director: A	Certification;	3 ☐ Suicide 6 4 ☐ Homicide	Could not b determined	280. Plac	ce of Injury - At h ding, etc. (Speci	nome, farm, s	treet, factory, office		2	8f. Location (S	treet and	Number or Ru	Iral Route Number.
	urs aft rai Di			3.0-24.1			5	nip			00 01	Time	31-	Min
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical			niner: On the			th occurred at the threat the threat						
	To th within To th compl	Me	29b. Signature and title	of certifier		DAA			se number	_			signed (Mont	
)	4.		· +st	1/4		Tolla	rip		O.C.M	.E.	A	April	10, 20	005
	',		36 Name and address	of person who	completed ca	uso of death (Ite	m 23a) (Type	n Street	, Bal	timor	e, Mary	lanc	1 21201	
	Sta	ate	31. Date filed (Month, D	Day, Year)	32.	Registrar's Sign	ature							
	Regist		APR 1	2, 7005	March	J. B.	Mary	E)					10	

DHMH 17 Rev 1/2001

hysici					and Mental Hy 26-05 tas		0 0 0
	an	Decedent's Name (First, Middle, Last) Edward R	icky Kloid	1	2. Date of De Month	Day Year	3. Time of Death
/Medic	cal.	4a. Facility Name (If not institution, give street and number)	- RIOIO	4b. City, Town, or Location	APRIL of Death	06,2005 4c. County of Dea	3:10a
Examin		HARBOR HOSPITAL		BALTIMORE C	ITY	N/A	
uneral rector		213 80 4241 1DXM 2DF	(In yrs. last birthday) 46 Yrs.	If Under 1 Year If Under Months Days Hours	Min. S. Date of Bi (Month, Di June 2	av Year)	rthplace (State or Foreig country) aryland
* =		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
F 2	tor	Maryland Anne Arundel	Baltim	ore			1 ☐ Yes 2 🔀 No
or 28	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?
18 23a	erai	408 Waverly Avenue 11. Marital Status 12. Was Decedent Expression 12. Was Decedent Expression 12. Was Decedent Expression 13. Was Decedent Expression 14. Was Decedent E	ver in U.S. 13	21225	rigin? (Specify Yes or N		encan Indian.
natural', or itams 23a or 28a-f show dical Examinatinasi bamulihad at	by Funerai	1 Meyer Married 2 Married 1 Yes 2 No. 1 Ves 3 Widowed 4 Divorced Year or Dates:		Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 1 ☐ Yes 2 No Specify		Specify: Wh	
natur Jical	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during mo	est of working	16b. Kind of Business	s/Industry
than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+ 12th	.)	DO NOT use retired) er worked		N/A	
kad othar than "natui ic avant, tre Medical	To Be Co	17. Father's Name (First, Middle, Last) Edward M. Kloid	I		ner's Name <i>(First, Middle</i> Mary Shirle		
If item 27 Is marked of or other traumatic eve		19a. Informant's Name/Relationship (Type, Print) Edward Kloid / father		ng Address (Street and Numb Vaverly Avenue		oer, City or Town, State, ore, Marylan	
itam 27 othar tra		20a. Method of Disposition	20b. Place of Dispo	matory or other place)	Date	20c. Location - City of	
ortant: If its injury or o e.		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		-	4/9/2005	Baltimore,	
Important: I any injury o once.		21. Signature of Funeral Service Licensee	//	2. Name and Address of Faci			
sician edical miner	er	resulting in death)		ion with comp			Interval Between Onset and Death
Jsit	듣	Cause. Enter Underlying Cause (Disease or injury	consequence of):				
y the attending physician and tched for use as the burial-transit	nysician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of): f pregnancy Fetal death 35	□Ectopic pregnancy		23d. Date of de Month	elivery Day Year
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ate has been signed by the attending phy: page 2 should be detached for use as the	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but Liver cirrhosis	consequence of): If pregnancy I Fetal death 30 Ime of death 50	☐ Other (specify)	24a. Was auto	Month tobacco use contribute to Yes 2 No 3 Personal Prior to death?	Day Year to the cause of death? Probably 4 Unknown tutopsy findings available
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tor: After this certificate has been signed by the attending phy: the funeral director, page 2 should be detached for use as the	o Be Completed by Physician/Medical	If any, leading to immediate Cause. Into Underlying Cause Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	f pregnancy If	Other (specify) Inderlying cause given in Part 26. Place at 3 DOA Other: 4 Nork? 28c. Injury at Work? 1 Yes 2	24a. Was auto perful 1 X Yes ce of Death (Check only Nursing Home 5 Res 28d. Describe	Month Yes 2 No 3 P san prior to death? 2 No One) idence 6 Other (Special Control of the contro	Day Year to the cause of death? Probably 4 Unknown tutopsy findings available completion of cause of s 2 \(\subseteq No \) with tunk Rural Route Number, verly Avenue
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			For State Registrar	State of Maryland /		rtment of Heali		ntal Hygie	2000	12370
	0.		Decedent's Name (First, Middle, La) A C			Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic	al		RBARA KOTERU	147	W. O'r. True		PRIL	5 2005 4c. County of Dear	
	Examin	er	4a. Facility Name (If not institution, giv			4b. City, Town, or Loca Baltimo			N/A	m
	Funeral		Social Security Number 6. 5	Sex 7. Age (In yrs. last I	birthday)	If Under 1 Year If U	nder 24 Hrs. 8.	Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry)
	Director		212 12 0022	1□M 2 ¾ F 83	Yrs.	Months Days Ho		uly 30,		ryĺand
	and ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	Maryland N/A	Bal	ltimo	ore				1 X Yes 2 No
	ith the)irec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	s 23a	ral	3546 Fourth St	12. Was Decedent Ever in U.S.	12 1	21225		Voc or No.	U.S.	anican Indian
' O	fter de ritam	Funeral Director	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		Vas Decedent of Hispani Yes, specify Cuban, Me		an, etc.)	Black, Whi	te, etc.
21215-0036	ours a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		A .	ecify:		Specify: W	
5-0	"natu	Completed	15. Decedent's E (Specify only highest gr		(Give	lent's Usual Occupation kind of work done during DO NOT use retired)	most of working		b. Kind of Business outh Balt	
77	d within iene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		ptionist			General H	lospital
b	al Hyg s otha	Be C	17. Father's Name (First, Middle, Last			18. 8	Mother's Name (F			
yla	ould by Ment	To		Brzuchalski	0) 14 11	4 11 (2)		eth Hal		Zio Codol
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any njury or other traumatic avant, the Medical Examinat must be notified at ance.		19a. Informant's Name/Relationship Betty Sinz / Dar			g Address <i>(Street and N</i> inwood Aven			e, Maryla	
ē,	s 1 an f Heal itam 2 othar		20a. Method of Disposition	ceme	of Dispo	sition (Name of natory or other place)	Date	200	c. Location - City or	Town, State
<u>=</u>	Page ment o ant: If ury or	- 12	1 XBurial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Special Control of the C	Hemoval from State	Cros	ss Cemetery		00		Maryland
Baltimore,	permit. Departr Importa any nji		21. Signature of Funeral Service Lice	insge	-	. Name and Address of I				
	205 8 9		23a. Part Enter the disease, or cog	Dications that caused the death.	9					y1and 21225 Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.						Interval Between Onset and Death THIRM MINU.
	/Medical		disease or condition resulting in death)	Due to (or as a consequence		AFARCITOIN				THIRTY
X	Examiner	L	Sequentially list conditions,	b. SEPTIC SI						MINUTES
_	led nsit	nine	Sequentially list conditions, and bed a stain reclaim cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons squence		CT INFECT	171			THREE
Ć.	execu in and ial-tra	Examine	that initiated events resulting in death) Last	Due to (or as a consequence		01 111 114	101			
8760,	certificate be executed nding physician and use as the burial-transit	edicai		d						
9	leath certifica attending ph I for use as th		IF FEMALE:	23c. If yes, outcome of pregnancy					23d. Date of de	livery
Вох	atte atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 Fetal death		Ectopic pregnancy Other (specify)			Month	Day Year
Ö.	that the de led by the a detached	hysi	9 Unknown	9□ Unknown						
S, D	es Ded	by	Part II. Other significant conditions	4	g in the u	nderlying cause given in	Part I.	23e. Did tobac		o the cause of death? robably 4 □Unknown
ord	requi	eted	HYPERTENSII	•				24a. Was an	30,	utopsy findings available
Vital Records,	e las has je 2	omple	CHRONIC RE	ENAL INSUFFICI	ENC	/		autopsy	dy prior to death?	completion of cause of
ta	i cian : Th certificate ector, pag	e C	25. Was case referred to medical			26.	Place of Death (C		No 1 □ Ye	s 2 No
of V	\$ S D	To B	examiner? 1 ☐ Yes 2 ☑ No		Outpatier				ce 6 ⊡Other (Spe	ecify)
o uc	ling After une	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	(Month, Day Year)	b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes		I. Describe how	injury occurred	
Division	att att	ficat	2 Accident investigate 3 Suicide 6 Could not determine	be 28e. Place of Injury - At home	, farm, str			. Location (Stree	et and Number or R	ural Route Number,
Ö	s after s after al Dira	Certification:	4 Homicide	building, etc. (Specify)				City or Town, S	этате)	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical (29a. Certifier 1 Certifying F (Check only one)	Physician: To the best of my knowled miner: On the basis of examination and manner stated.	dge, deat and/or in	n occurred at the time, da vestigation, in my opinior	ate and place, and n, death occurred	I due to the caus at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and hitle of certifier	domo-Pau		29c. License nun	mber		. Date signed (Mon	
			MEDI	CAL INTERN		RES	000	A	PRIL 5	2005
	12		30. Name and address of person who	u 3001 S. HAN	OVER	Print) STREET, 1	BALTIMO	RE, M	0 21225	>
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 2 2	32 Registrar's Signature	Ro	aulis		,		
		4-1		100000000000000000000000000000000000000	-					

		•	1 - For State Registrar	State of I	Maryland /	•	artment of				ene)	05	12371
	Physici		1. Decedent's Name (First, Middle, Las	")						Date of Death Month	Day	Year	3. Time of Death
	/Medic		Ray Frankl	in Lync	h					April		05	6:30а м
	Examin	er	4a. Facility Name (If not institution, give	street and numb	er)			n, or Location	of Death			y of Death	
			100 Maple Drive		A	took of 1	Ann If Under 1 Ye	apolis	74 Hre	0 Date of Dist	Ann	e Aru	
L	Funeral		5. Social Security Number 6. Sec. 182–14–5177	x 7. M 2□ F	Age (In yrs. last b 82	iπnαay) Yrs.	Months Da		Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent		02					JUN 12,	1922	Penn	sylvania
	/land		10a. State 10b. County		10c. City, Tox	wn or Lo	cation					1	0d. Inside City Limits
	Mar 9-f st	ţo	Maryland Anne An	undel			Anna	polis					1 ☐ Yes 2 X No
	or 28	irec	10e. Street and Number				10f. Zip Cod			10	g. Citizen of	What Cour	ntry?
	th wil	ai	100 Maple Drive				2	1403				USA	
	r dea	Funerai Director	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. 1942-1945	13.	Was Decedent	of Hispanic Or Juban, Mexica	igin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)		ce - Americack, White,	
36	filed within 72 hours after death with the Maryland Hygiene. other than "neturel", or items 23e or 28e-f show ent, the Modical Examinational be mailfied at	by Ft	1 Never Married 2 Married 3 Widowed 4 Divorced	1X Yes 2 If Yes, Give.	1942−1943 18951−1953	2	1 □ Yes 2X🗓	No Specify	:		Speci	ty: W	hite
Ö	hour turel	q pe	15. Decedent's Ed				dent's Usual Oc	cupation		1	6b. Kind of E	Rucinoce/In	duetra
21215-0036	in 72	Completed	(Specify only highest gra-	de completed)		(Give	kind of work do DO NOT use re	ne during mos	st of worki	ng	OD. KING OF E	Jusii 1633/111	dustry
7	iene.	E O	Elementary/Secondary (0-12)	College (1-4 2		\nal	yst				NSA		
ק	otha otha	Be C	17. Father's Name (First, Middle, Last)				4	18. Moth	er's Name	(First, Middle, M	aiden Suma	me)	
lar	should be and Mental s marked o	To E	James Ephraim Ly	nch .					0rr	alee Wir	ngrove		
Maryland	2 sho and N Is ma		19a. Informant's Name/Relationship (7	ype, Print)	19	b. Maili	ng Address (Str	eet and Numb	er or Rura	l Route Number,	City or Town	n, State. Zip	Code)
	and and a salth n 27		Anna Mae Lynch/wi	.fe			Maple D	rive .	Annaç	olis, M			
ore	Pages 1 nent of H int: If itan		20a. Method of Disposition 1 Burial 2 Toremation 3	Removal from Sta	cemet	ary, crei	natory or other	place)			0c. Location	•	
altimore,	tmen tant:		`4 □ Donation 5 □ Other (Specify		Metro		ematory			_	Baltim		MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other traumatic avent. It is Monical Examination and be notified at once.		21. Signature of Puneral Service Lisen	ic Uma	d	Ĉ	rematio	n Soci	ety c	of Maryla	and, I	nc.	
	10240			onald	sed the death. Do	1 2	99 Hred	erick]	Road	Baltimo	ore, M	D 212	28 Approximate
	an and		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on eac	h line.	1	1				o.,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Acut	as a consequence	110	MINNE	7					
ı	Examiner			Due to (or	as a consequence	3 OT): A	Homa	scler	106.14	:			100
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequence	of):	res o.	JULE 1	0/4	<u> </u>			1096
	cuted od ransit	Examiner	that initiated events	c									
oʻ	a exer	EX	resulting in death) Last		as a consequence	of):							
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9	ertific ling p		IF FEMALE:	00. 16									
Вох	eath certific attending pl I for use as t	ian/	23b. Was decedent pregnant in the past 12 months?		h 2 Fetal deat		Ectopic pregna					ate of deliver onth	ery Day Year
o.	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnar 9☐Unknow	nt at time of death n	51.	Other (specify	"/					
۵.	res that the de signed by the be detached		Part II. Other significant conditions of	entributing to dea	th but not resulting	in the u	nderlying cause	given in Part	1.	23e. Did toba	acco use cor	ntribute to t	he cause of death?
Vital Records,	law requires as been sign 2 should be	d by	Diabetes Mel	1416						1 ☐ Yes	3 2 341 6	3 □ Prot	oably 4 DUnknown
00	w requir	iete								24a. Was an	24b.	Were auto	psy findings available
Re	9 4 9	Completed								autopsy perform 1 Yes 2	ed?	death?	mpletion of cause of
tal	ician: Th certificate rector, pag	0	25. Was case referred to medical					26. Plac	e of Death	(Check only one		1 1 1 1 1 1 1 1	21.69
	Q 15	To B	examiner? 1 Yes 2 N	Hospital: 1 🗌 Inp	atient 2 ER/C	Outpatie	nt 3 DOA	Other: 4 N	ursing Hor	ne 5 Desider	nce 6 □Ot	her (Specif	y)
n of	Jing Pl J. After th funeral		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of (Month,	Injury 28b. Day Year)	Time o		njury at Work?		28d. Describe how	w injury occu	rred	
Sio	Attending r death. actor: After by the fune	cati	2 Accident investigation					1 ☐ Yes 2 ☐					
Division	l or Atteno after death Diractor:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	280. Flace 0	f Injury - At home, , etc. <i>(Specify)</i>	farm, st	reet, factory, off	ice	1	28f. Location (Str. City or Town,		iber or Rura	M Route Number,
	pital ours a aral C		29a. Certifier 1 Dertifying Ph	veicion: To the h	act of my knowled	no deat	h occurred at th	e time, date a	nd place :	and due to the car	usa(s) and m	20001 20 0	tated
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exen		is of examination a								
	o the	Me	29b. Signature and title of certifier				29c. Lic	ense number		29	d. Date sign	ed (Month,	Day, Year)
)	0		Klon Moure	KI)			D 19	5529	00		04-12	2-05	_
	1041		30. Nameland address of person who	completed cause	of death (Item 23a) (Type,	Print)		1				
	10		Jon B. Lowe SO	2009 11	DEWATER	260	long 1.).r., ft	MNO	40/15,	MO.	2140	01
	Sta		31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signature		. 1		•	,			
D.	Regist	14 g	APR	1 2 2005	Blow	1	T Apa			yolis,			
Uh	IMH 17 Rev 1/2	UUI											

ORIGINAL

ADH unpend item/23a,27, per ME, C843,5/31/05 Flore Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene WENDELL LOWERS 05 - 2321Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Paige Lowers APRIL 2005 1140 Wendell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE CITY MARYLAND GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 05 11 71 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F Yrs Director 33 ΜĎ 214-08-7418 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow traumatic evant, the Medical Exercities must be notified at XXYes 2 □ No Directo MDNA Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ō 21215 U.S.A. Items 23a 6630 Eberle Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1X Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Black "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 73 th and Mental Hygiene." 7 Is marked other than "nu Elementary/Secondary (0-12) College (1-4or 5+) Unemployed Unemployed 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ann M. Hughes Robert P. Lowers Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 91320 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health ar Important: If item 27 la any injury or other trav QDG. 1748 Blue Canyon Street, Thousand Oaks, Jeffrey Lowers-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc.4/8/05 Baltimore, of Funeral Service bicensee 22. Name and Address of Facility xmala March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final Pnysician Atherosclerotic Cardiovascular Disease resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical as the t d IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 Yes Completed been 24a. Was an certificate has autopsy performed? Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 3X DOA 2 N Yes 2 No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After Attanding 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death
Diractor: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 - Homicide the Hospital or within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 0 OCME

State Registrar

31. Date filed (Month, Day, Year) 32.

406

APR 1 2 2005

30. Name and

32. Registrar's Signature

address of person who completed ause of death (Item 23a) (Type, Print)

111 Penn Street

APRIL 3, 2005

Baltimore, Maryland 21201

			1 - State Registrar	State of Maryl	•	artment of H			iene eg. No: 005	12373
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
	Physici /Medic		Thelma Jewel	l Lott	,			April	07 2005	4:50 PM
	Examin		4a. Facility Name (If not institution, give stre				r Location of Death	1	4c. County of De	
			2000 Kurtz Avenue 5. Social Security Number 6. Sex		last birthday	Pase If Under 1 Year	adena I If Under 24 Hrs.	C Date of Birth	Anne	Arundel
E	Funeral Director			2C X F	yrs. last birthday) 65 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Sept. 2	Year) 939	rthplace (State or Foreign country)
	ъ		Usual Residence of Decedent					100pu. 2		
	show	_	10a. State 10b. County Maryland Anne Arun		. City, Town or Lo		Pasadena			10d. Inside City Limits 1 ☐ Yes 2 💆 No
	he Me	Director	10e. Street and Number	dei			- a 3a a c i i a		0.00	
	with I	DI	2000 Kurtz Avenue			10f. Zip Code	21122		og. Citizen of What C	ountry?
	Heath TIS 23	Funeral		Was Decedent Ever	in U.S. 13. V	Was Decedent of H f Yes, specify Cuba		pecify Yes or No-	14. Race - Am	erican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar rust be notified at ance.	by Fur	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔯 No If Yes, Give		f Yes, specify Cuba 1 □ Yes 2 ☑ No	an, Mexican, Puert Specify:	o Rican, etc.)	Black, Wh	_{ite, etc.} White
8	hour	ed b	15. Decedent's Educat	Year or Dates:	16a. Deced	dent's Usual Occup	ation		16b. Kind of Busines	s/Industry
215	nin 72 In "na Mediis	Completed	(Specify only highest grade of Elementary/Secondary (0-12)		(Give	kind of work done of OO NOT use retired	during most of wor d)	king	TOD. THIS OF DUSINGS.	gilladdily
2	giene er tha	Com	12	4	Exec	utive As	sistant		Investme	nt Firm
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<u>Ş</u>	Men narke	ပ	Anderson Smith	0.11	401 14 11		Jeanett			
Maryland 21215-0036	d2sh thand i7 is n traum		19a. Informant's Name/Relationship (Туре, Faion L. Lott (spouse)) Kurtz A			, City or Town, State, MD 21122	Zip Code)
စ်	Heal Heal tam 2		20a. Method of Disposition		Ob. Place of Dispo	sition (Name of			20c. Location - City o	r Town, State
OE.	Pages ent of nt: If i		1 ☐ Burial 2 🖾 Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify) 』	oval from State	-	matory or other place ematory II			Baltimore,	Maryland
Baltimore,	partm portal y inju		21. Signatur, of Funeral Servic Licen e	11 11		. Name and Addres				Home, P.A.
m	P P P P		Muschell	Stalle	mal			_ '	dena, MD 2	1122
ı.			23a. Part . Enter the disease, or complicat shock, or heart failure. List only one						est,	Approximate Interval Between Onset and Death
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8760,	icate be executed physician and s the burial-transit	dical	d.			_				
9	ding p	/Mec	IF FEMALE:	If yes, outcome of pre	agnaney/					-
Вох	eath certific attending p I for use as	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ I	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
o.	that the de led by the a detached f	ysle	1 ☐ Yes 2 📉 No 9 ☐ Unknown	9□ Unknown	0. 404					
ď	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as	by Pl	Part II. Other significant conditions contril	outing to death but not	t resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
rd	w require been sig should b	ed t						1 □ Ye	es 21⊠No 3∏P	robably 4 Unknown
Records,	e law re has be je 2 sho	Completed						24a. Was a autops	y prior to	utopsy findings available completion of cause of
	The cate h	Соп						perform	ned? death? 2 ☐ No 1 ☐ Ye	s 2 No
Vital	ician: certific ector.	Be	25. Was case referred to medical examiner?	pital:		t 3Cl DOA Othe	0.00	th (Check only on		
ot	Phys r this ral dir	: To	TES 250 NO	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien 28b. Time of	I JUDON	4 🗆 Mursing II		ence 6 Other (Spenow injury occurred	ecify)
O	nding th: : Afte	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ur) Injury	Worl	k? Yes 2 □No		,.,	
Division of	Attandi er death. ector: A by the fu	Certification;	a □ Culaida 6 □ Could not be □	28e. Place of Injury - A building, etc. (Sp	At home, farm, str	eet, factory, office		28f. Location (St. City or Town	reet and Number or F	lural Route Number,
	tal or A	Cert	4 - Homodo	building, etc. (o)				Ony or row	., 51416)	
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner							
	Fo the Mithin Fo the	Me	29b. Signature and title of certifier			29c. License	e number	2	9d. Date signed (Mon	th, Day, Year)
	í.		1 Intimes			315	8320		4/8/05	
	1		30. Name and address of person whe comp		-	Print)		. (,1		C 3
			31. Date filed (Month, Pay, Year) 2001	32. Po gistrar's S		acus a	o with	hnoille	70 510	7.5.
	Sta Registr		AFR 1 2 200	Strew		and				

		-	For State Registrar	State of Ma	•	epartment of F Certificate of			ene 005	12374
>	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, 4a. Facility Name (If not institution,	give street and number)	n Pital	4b. City, Town, o	or Location of Death	2. Date of Death	Day 7 Year 4c. County of Dea Anne	3. Time of Death 5 4:00 AM Arundel
	Funeral Director			6. Sex 7. Age	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) June 17,	9. Bir 1927 Wa	thplace (State or Foreign country) shington, DC
	he Maryland Be-f ehow otified at	Director		Arundel	Gamb	rills		100	. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or itams 23a or 28e-f ehow other than "natural", or itams 23a or 28e-f ehow event, the Midral Examinar must be notified at	Funeral Dire	10e. Street and Number 927 Autumnwood 11. Marital Status 1 □ Never Married ※XMarrie	12. Was Decedent E Armed Forces?		10f. Zip Code 13. Was Decedent of If Yes, specify Cub	21054 Hispanic Origin? (Sp an, Mexican, Puerto		USA 14. Race - Am Black, Whi	erican Indian, te, etc.
21215-0036	nin 72 hours aft in "natural", or Medical Exami	Completed by F	3 Widowed 4 Divorced 15. Decadent (Specify only highest Elementary/Secondary (0-12)	If Yes, Give Year or Dates: s Education	16a. D	1 ☐ Yes 2XXNo eccedent's Usual Occu. Give kind of work done ife. DO NOT use retire	pation during most of work	king 16	Specify:	White
land 212	should be filed within and Mental Hygiene. marked other than "metic event, the W.S.	To Be Com	12 17. Father's Name (First, Middle, L Carlyle Elmore	ast)		ecretary		Pone (First, Middle, Ma		y Schools
ore, Maryland	s 1 and 2 s f Health ar Itam 27 is other trau		19a. Informant's Name/Relationsh Joseph A. Loga 20a. Method of Disposition 1 X Burial 2 □ Cremation	an, Sr., (Hus	sband)	Mailing Address (Street 927 Autumn Disposition (Name of crematory or other pla	wood Driv	e, Gambri		21054
Baltimore,	permit. Pages Department of H Important: If Ite any injury or of		4 Donation 5 Other (Sc. 21. Signature of Futher Service L	ecify)	Fort L	22. Name and Addre Hardesty	ess of Facility Funeral		rentwood, is, MD 21	
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68760,	icate be executed physician and s the burial-transit	cal	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):				meny years
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	S y		23d. Date of de Month	olivery Day Year
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tal Records,	ician: The law r. certificate has be rector, page 2 sh	e Completed	25. Was case referred to medical				26 Place of Dea	24a. Was an autopsy performe 1 Tyes 2	prior to death? No 1 Ye	
ion of Vital	ding Phys	To B	was user to the date of the d			me of 28c. Inju	her: 4 Nursing H	ome 5 Residen 28d. Describe how	ce 6 □Other (Spe	ecify)
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	To the Hospital or within 24 hours after To tha Funaral Dir completely filled in	Medical	29a. Certifier 1 Certifyin (Check only one) 2 Medical loop with Medical loop one)	g Physician: To the best of examiner: On the basis of and manner sta	examination and	or investigation, in my	opinion, death occu	rred at the time, dat	e and place, and du	e to the cause(s)
1	of the same of the		30. Name and address of person	who completed cause of de	eath (Item 23a) (T	ype, Print)	(1) Pur	mio MD C	4/7/05	•
	Sta Regist	ate rar	Mirza Nusaire 31. Date filed (Month, Day, Year)	32 Benistra	r's Signature	Park Dr.,	Gien Bur	nie, rii 2	.1001	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1150P M Beative Love April 2005 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Northwest Hospital Center Baltimore Randalistown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 ☐ M 2 🗗 F 214-38-4466 Usual Residence of Decedent Yrs. **Director** 10b. County 10d. Inside City Limit& 10a. State 10c. City, Town or Location 28a-f show other treumatic event, the Madical Examiner must be notified at Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced "naturel" permit. Pages 1 and 2 should be filed within 72 bepartment of Health and Mental Hygiene. Importent: If item 271s marked other than "naturany injury or other treumatic supplements." 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-40[5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Veneu 19a. Informant's Name/Relations ip (Type, I 19b. Mailing Address (Street and Jumber or Rural Route Number, City or Town, State, Zip Code) 'arrer' 146 20c. Lecation - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3 Removal from State 1 Burial 2 Cremation ubneu Vallei Timonum 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Greene Funcial Sevices lead Kendallotown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Anoxic Exceptialopathy /Medical Due to (or as a consequence of): **Examiner** severe anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 202 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 70 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00060567 Aail 5,2005

DHMH 17 Rev 1/2001

State Registrar person in a complete cause of death (Item 23a) (Type, Print) Mary by Mcjia, MI)

Manyland

Randalis town,

Registrar's Signature

old court Road

5901

31. Date filed (Month, Day, Year)

athent known as Frances Lasov

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and Item#22, perFH, C642, 4/12/05 TI
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 10 00 Month **Physician** La Sov April Frances 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore If Under 1 Year Baltimore City If Under 24 Hrs. N/A Sinal of 5. Social Security Number 8. Date of Birth 10/04/1925 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 X F Hours Min 79 218-14-6679 Yrs. MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic evant, the Medical Exal directment be notified at 1 ☐ Yes 2 No BALTIMORE RANDALLSTOWN MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 1 SPINNERS COURT U.S.A. Itama 23e APT. 1A Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: Specify: 3 X Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be fi SACKS FREDA KALIN MAX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Itam 27 i STANLEY La Sov / SON 349 HIGH KNOB LANE REISTERSTOWN, MD. 21136 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If Its any injury or o once. ō HILLTOP SERVICE CORP. 04/11/2005 TOWSON, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sol Levinson Bros. Inc 8900 Reisterstown Rd. Pikesville, MD 21208 Tole 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia Week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consucuence of Examiner If any, leading to kinn aditional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed Pulmonary 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼No 24a. Was an Obstructive autopsy 2 **X** No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 ho To tha Fund completely f (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8 2005 who completed cause of death (Item 23a) (Type, Print) of person Sinai George Hospita Kuo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Month **Physician** RACSA LEDER 2:15 PM APRIL 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** +COSPITAL BALTIMORE TZZWHTDIOU RANDALLSTOWN If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 28 Date of Birth Day, Year) DEC. 28, 1913 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F BELARUS Yrs. 91 215-96-2351 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 EAST CHERRY HILL ROAD 21136 USA or Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2X No Specify. Specify 3 ₩ Widowed 4 Divorced "natural', 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than. Elementary/Secondary (0-12) College (1-4or 5+) 4 MANAGER RETAIL. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (UNKNOWN) (UNKNOWN) (UNKNOWN) (UNKNOWN) ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 EAST CHERRY HILL ROAD - REISTERSTOWN, MD 21136 MARIA LEDER / DAUGHTER-IN-LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PARK 04/10/2005 RANDALLSTOWN, MD `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 21. Signature of Funeral Service Licenses Edwara C. Klysie Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final EDEMA **Physician** PULMONAR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ AJUAN MANGA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 PNo 1 Donpatient Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ANatural 2 🗆 No after death Diractor: 2 Accident in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 [] Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54352 *PRIL 2005 NORTHWEST HOSPITAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 OLD ROAD RANDALLSTOWN MIRCEA TODOR COURT MD 21133 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

DHMH 17 Rev 1/2001

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	9		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
	Funeval		JEWISH CONVALESCENT CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	BALTIMORE ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	BALTIM 9. Birti	hplace (State or Foreign
	Funeral Director		216-07-5427 1 M 2 M F 96 Yrs	Months Days Hours Min.	01/28/19	9ar) Co	untry) MD
	and w	Ì	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	Location			10d. Inside City Limits
	h the Maryland r 28a-f ahow r notified at	ō	MD BALTIMORE BALTIMO				1 ☐ Yes 2 ☑ No
	n the	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	untry?
	23a c		7920 SCOTTS LEVEL ROAD	21208		U.S.A.	
	er deg	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
35	72 hours after death with the Maryland natural; or Items 23a or 28a-f ahow Jical Evantiner must be notified al	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: WH	ITE
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Maryland 2	2 should and Men Ia marka aumatic			ailing Address (Street and Number or Ru		ity or Town, State, 2	Tip Code)
	itam 27		MINDY TOBY / GREAT NIECE 220	1 FALLS GABLE LANE	BALTIMORE Date 20	MD 2120)9 Town State
altımore,	00 0		1 M Burlai 2 Cremation 3 Hemoval nom State MOCEC MO	sposition (Name of crematory or other place) NTTEIODE		•	
			'4 □Donation 5 □Other (Specify) YIUSES YIUS	OO Name and Address of Facility	100000000000000000000000000000000000000	ALTIMORE,	
ñ	permit. Departi Importi any inj		Michael to	SUI L NWRSTERSTOWN	LEVINSON	V & BRUS.,	INC.
			23a. Part 1. Enter the disease, of complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest	, LOVIELE,	interval between
. 1	Physician	1	Immediate Cause (Final disease or condition resulting in death)	15 DISGOSE			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				1 TUIL
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury				
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8760,	be executed sician and burial-transit	Ical Ex	resulting in death) Last Due to (or as a consequence of):				
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ŏ	death certificate be executed e attending physician and id for use as the burial-transif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of deli	
O. B		sicis	1 Yes 2 No	5 Other (specify)		Month	Day Year
<u>.</u>	that the dened by the stached to		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
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ecords,	The law requires that the tee has been signed by thoage 2 should be detache	Completed			24a. Was an	24b. Were au	topsy findings available
T .		mo			autopsy performe 1 Yes 2	d? death?	completion of cause of 2 No
Vita	ician: Th certificate rector, pag	Be (25. Was case referred medical examiner?		th (Check only one)		
	Physi this c	. To	1		ome 5 Residence		city)
O	Attending Physician: r death. actor: After this certifici by the funeral director,	tlon	27. Many r of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) Injury		200. 20001120 11011	mjary cocarroa	
Division of	l or Attendi after death. Diractor: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,
	ital or irs afte ral Dir lled in						
	To the Hospital or At within 24 hours after of To tha Funaral Dirac completely filled in by	edical	29a. Certifier (Check only one) 2□ Madical Examinar: On the bast of my knowledge, of the house of examination and/of and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as a and place, and due	to the cause(s)
	To the Ho within 24 I To tha Fu completely	Me	29b. Signature and fittle of certifier	29c. License number	29d	. Date signed (Monti	h, Day, Year)
)			I Andon	0 11 1514	DP	WRIL 9	2705.
1	5		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	1 1	han	11 211 =
1) Sta	to	31. Date filed (Month, Day, Year) #32. Registrar's Signature	OHO PRIS.	tre, 11	114/14	11 5/368
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... Decedent's Name (First Middle Last) 2 Date of Death

Days

10f. Zip Code

Mc CALLISTER

7. Age (In yrs. last birthday

10c. City, Town or Location

BALTIMORE

36

12. Was Decedent Ever in U.S. Armed Forces?

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Highene. Important: If item 27 is marked other than "natural", or items 23s or 28s 1 show any injury or other traumatic event, the Medical Examination notified at once. To Be Completed by Funeral Director

1 - For State Registrar

10a State

MD.

BIANCHA

5. Social Security/Number

10e. Street and Number

216-94-4961 Usual Residence of Decedent

NICOLE

1□ M 2√2 F

N/A

4a. Facility Name (If not institution, give street and number)

10b. County

3405 AVONDALE AVENUE

Physician /Medical

> Examiner Physician/Medical þ Completed Be Certification: To

Examiner The law requires that the death certificate be executed use as the burial-transi P.O. Division of Vital Records, page 2 should be or Attending Physician: After after death. the in by t within 24 hours a

Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12TH UNKNOWN DELI CLERK 17. Father's Name (First, Middle, Last) MICHAEL FULTON 19a. Informant's Name/Relationship (Type, Print) PAULA Mc CALLISTER (AUNT) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) ZION CEMETERY 21. Signature Funeral Service Licensee LEWIS T. GWYNN 4517 PARK HEIGHTS 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dyne to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical exampler? 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Type.

4b. City, Town, or Location of Death 4c. County of Death N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 1968 MARYLAND Day Year) Hours 10d. Inside City Limits 1X Yes 2 □ No 10g. Citizen of What Country? 21215 U.S. OF A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No Specify: BLACK Specify. 16b. Kind of Business/Industry STORE (STOP, SHOP, SAVE 18. Mother's Name (First, Middle, Maiden Surname) Mc CALLISTER WALZETTA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4114 TWIN CIRCLE WAY BALTO., MD. 21227 20c. Location - City or Town, State 4/9/05 LANSDOWNE, MARYLAND LEWIS T. GWYNN FUNERAL HOME 21215-6393 **AVENUE** Approximate Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 1 Yes 2 No 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 4/05

State Registrar

			1 - For State Registrar		artment of Health and rtificate of Death	Mental Hygien	ZHHE	12380
	Physici /Medio		1. Decedent's Name (First, Middle, Last)		MINTZ	2. Date of Death Month APRIL	pay Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Dea	th 4	lc. County of Death	X
	Funeval		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Baltimore (B. Date of Birth	9 Birthol	ace (State or Foreign
	Funeral Director		250.58.0310 10 M 20		Months Days Hours Min		139 SOUTH	CAROUNA
	yland iow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10	Od. Inside City Limits
	Ba-fsh	Director	MD	BAT	MORE			1 Maryes 2 □ No
	hours after death with the Maryland tural', or Items 23a or 28a-f show al Examiner must be notified at		942 N. Collins	ton Ave.	10f. Zip Code 2120 5	10g. C	Citizen of What Count	ry?
	tems 2	Funeral	11 Marital Status . 12. Was I		Was Decedent of Hispanic Origin? (S If Yes, specify Cyban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White	
036	al', or l	ρ	If Yes	es 2 🗹 No , Give or Dates:	1 ☐ Yes 2 No Specify:		Specify: BU	ACK
15-0	72 hours "netural"	leted	15. Decedent's Education (Specify only highest grade complete	ed) (Give	dent's Usual Occupation kind of work done during most of wo	orking 16b.	Kind of Business/Ind	ustry
21215-0036	d within 72 ho giene. er than "netu	Completed	Elementary/Secondary (0-12) College	ge (1-4or 5+)	FORK LIFT	/	NDUSTRI	IAL
Maryland	uld be filed fental Hyg rked othe tic event,	To Be (17. Father's Name (First, Middle, Last) AMES MINT	2	18. Mother's Na	me (First, Middle, Maide A WANN	on Sumame) A MAKEK	
Mary	d 2 should th and Mer ?7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or R	ural Route Number, City	or Town, State, Zip	Code)
	1 an Heal em 2 ther	(20a. Method of Disposition	WIFE 942 20b. Place of Dispo	osition (Name of	Date 20c.	MOKE M Location - City or Tov	D H20S wn, State
Baltimore	Page nent c nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal for 4 ☐ Donation 5 ☐ Other (Specify)	om State ARBUTUS	CEMETERY 4	9.05 A	RBUTUS, MI	PRYCAND
Balt	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service Licensee	Grue 4	2. Name and Address of Facility V	AVEHN C. G BAITI MO	TREENE FUI RE, MARY!	MEKAL HOME
			23a. Part1. Enter the disease, or coreplications to shock, or heart failure. List only one cause	on each line.				Approximate Interval Between
	Physician /Medical		resulting in death)	HEYNE -STOK	ES RESPIRA	TION		Onset and Death
	Examiner			to (or as a consequence of): erebro Vascul a	r Accident			6 weeks
	ed	Examiner		to (or as a consequence of):				
Ć.	ate be executed hysician and the burial-transi	Exan	that initiated events c.	to (or as a consequence of):				
8760		dlcal	d					
Box 6	death certifica e attending ph ed for use as t	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes	outcome of pregnancy			23d. Date of deliver	
Ö.		Physiclan/Me	in the past 12 months?		Ectopic pregnancy Other (specify)			Day Year
P.0.	ac >c =	/ Phy	9 Unknown Part II. Other significant conditions contributing		nderlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
rds	w requires that the been signed by th should be detache	ed pa		ion, Diabetes		1 ☐ Yes 2	2 □ No 3 Proba	bly 4 Unknown
Division of Vital Records,	aw S S	Completed by				24a. Was an autopsy	prior to com	sy findings available pletion of cause of
alF		e Cor	25. Was case referred to medical			performed? 1 ☐ Yes 2 N	o 1 Yes 2	2 □ No
Ţ	Physician: this certific ral director.	To Be	examiner?	Xinpatient 2 ☐ ER/Outpatier		ath (Check only one) Iome 5 Residence	6 □Other (Specify)	
0 00	ing Ph		1 Natural 5 Pending	ate of Injury 28b. Time of Injury Injury	f 28c. Injury at Work?	28d. Describe how inju	ıry occurred	
risio	Attending ir death. ector: After by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. P	ace of Injury - At home, farm, str	M 1 ☐ Yes 2 ☐ No reet, factory, office	28f. Location (Street a	nd Number or Rural	Route Number
Ö	tal or as after al Dire	Certi	4 Homicide	uilding, etc. (Specify)		City or Town, Stat	Θ)	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	Check only 2 Medical Examiner: On the	the best of my knowledge, death e basis of examination and/or in anner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the cause(surred at the time, date an	s) and manner as stated and place, and due to t	ted. he cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier		29c. License number		ate signed (Month, D.	
	\sim		Doublut MEDS			AP	ril 5,20	105
5			30. Name and address of person who completed of JORDAN PRUTKIN, JOHNS	ause of death (Item 23a) (Type, HUPKINS HOS/IT/	Print) NL, TOVER110, 600 N.	WOLFE ST., B	ILTIMORE, MI	0 31287
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 2005	2. Registrar's Signature	W			

State of Maryland / Department of Health and Mental Hygiene 🛭 🗎 5 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year KATHRYN McKELDIN Ε. 08 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not instruction, give street and number) County of Death Examiner 8. Date of Birth (Month, Day, Year) Oct.13,1943 Funeral 1 □ M 212 F Days 218-40-7941 Hours Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 8397 Baltimore Annapolis Blvd. 21122 or itema 23a U.S.A. Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White 3 ₩idowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Jess Salvers Mildred McDonough 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Deborah (Daughter) Kaya 6122 Avenue T. Brooklyn New York 11234 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important; if it any injury or o ö Holy Cross Cem. ³ 4 □ Donation 5 □ Other (Specify) 04 - 12 - 05Baltimore, Maryland 21. Signature of Fuperal Service License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21225 237 E. Patapsco Avenue, Baltimore, Marvland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Encaphalogathy Physician معسا C-hox: c /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 certificate has blirector, page 2 s autopsy 6 loc 1 1□ Yes 2 No director, 25. Was case referred to medical examiner?

1 Yes 2 0 Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To T Impatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Mann 1 Natural Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a
To the Funeral I
completely filled filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MN 405 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 1 2 2005 Registrar

			State RegistrarAMFND ITEM #5 F		artment of Health and M	Mental Hygier	F000 17007					
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death					
	Physici /Medic		Rose MI	Ster		APRIL O	- 1 / A M					
	Examin		4a. Fecility Name (If not institution, give street	and number)	4b. City, Town, or Location of Death	4	4c. County of Death					
			GOOD SAMARITAN		BALTIMORE		NA					
	Funeral Director		5. Social Security Number 6. Sex 1 M 3	7. Age (In yrs. last birthday) 6 7 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yee	9. Birthplace (State or Foreign Country)					
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits					
	ne Maryla 8a-f eho ziified a	ctor	MD N/a		BALTIMORE		1 Yes 2 □ No					
	th with the 23e or 2	ai Dire	2915 - E. Northe	en Packway	101. Zip Code 21214	10g. 0	Citizen of What Country? し・5. み・					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Departments if them 27 is marked other than "natural" or iteme 23a or 28a-f show important: if them 27 is marked other than "natural" or iteme 23a or 28a-f show eny injury or other traumatic event, I.z. Medical Exam nor must be notified a once.	Completed by Funeral Director	1 Never Married 2 Married 1 [TYes 2⊅No	Nas Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WhiTe					
21215-0036	thin 72 hou e. an "natura Wedical E	npieted	15. Decedent's Education (Specify only highest grade com, Elementary/Secondary (0·12)	oleted) (Give	lent's Usual Occupation kind of work done during most of work OO NOT use retired)	king	Kind of Business/Industry					
21	filed with Hygiene. Ather than	Col	1220	NIA	Sucretery							
pu	be file ital Hy od oth event	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid	en Sumame)					
yla	should be and Mental is marked of sumatic eve	2	KOCCO MIRABILE		ANNA							
Maryland	and 2 sho balth and n 27 is my er traum		19a. Informant's Name/Relationship (Type, Pr	int) 19b. Mailin	GLENOAL AUC.	ral Route Number, City Balto: Mu						
ē,	es 1 and of Health of Item 27 r other tr		20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place)	Date 20c.	Location - City or Town, State					
E	Page lent c int: If iry or		Burial 2 ☐ Cremation 3 ☐ Remove '4 ☐ Donation 5 ☐ Other (Specify)			2/05 B	relte. No.					
Baltimore,	permit. Pag Department Important: I eny injury o		21 Ignature of Funeral Service Licensee	-00. 22 it	Name and Address of Facility ST ARTLEM MILLER-ST 37 has followed	Paite M	RAI HOME CHTD.					
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. Do not ent-	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death					
760,	Physician /Medical /Medical Assicien and partial: Italian	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	LUNG CAN	CER						
. Bo	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/Med	in the past 12 months?		Ectopic pregnancy		23d. Date of delivery Month Day Year					
<u>a</u>	w requires that the been signed by the should be detache	d by Pi	Part II. Dther significent conditions contribute HYPERTENSIO		nderlying cause given in Part I.		o use contribute to the cause of death?					
Rec	sician: The law req certificate has beer irector, page 2 shou	Completed by	CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24a. Was an autopsy performed? 1 Yes ARO 1 Yes 2									
Vital	rtifica	0	25. Was case referred to medical		26. Place of Dea	th (Check only one)						
>	> 00	To B	examiner? 1 Yes 22 No Hospita	II: 1 ER/Outpatient 2 ER/Outpatien	t 3 DOA Other: 4 Nursing H	ome 5 Residence	6 □Other (Specify)					
O	9 Ph ler th leral	Ë		a. Date of Injury (Month, Day Yeer) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	jury occurred					
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Division of	al or Atte after de f Directo d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined 286	 Place of Injury - At home, farm, str building, etc. (Specify) 	eet, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Examiner: C		n occurred at the time, date and place vestigation, in my opinion, death occu							
	To the within To the	Me	29b. Signature and title of certifier .		29c. License number	29d. I	Date signed (Month, Dey, Year)					
	->-0		> 6 Bourelle	, M.D.	P15306	L	109105					
	σ_i		30. Name and address of person who complete	ed cause of death (Item 23a) (Type		RITANI H	SPITAL					
	10		GILBERT BOURTE		RAVEN BLVD, B							
	Str	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 W.		-/111161630					
	Regist		APR 1 2 200	Meseure St A	parte							

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			1 - For State Registrar	State of Mary		artment of H			ene () () 5	12383
	Physici	an	Decedent's Name (First, Middle, Las	st)	Ma		_	2. Date of Death Month	Day Ye	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give	street and number)	111	grude, 4b. City, Town, o	or Location of Death	APRIL-	9 - 0_ 4c. County of D	
	Lxuiiii		3306 ORLA	ENDO AL	1enue	BAI	timore	,		
	Funeral		5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		90 113			JANS,	1912	MARGIANIS
	urylanc show	la.	10a. State 10b. County	10	c. City, Town or Lo					10d. Inside City Limits
	he Ma 28a-f	Director	Maryhous		BAIT	·				1 Yes 2 No
	with t	i Dir	10e. Street and Number 3306 ORLAN	o Avenu	, ,	10f. Zip Code	214	109	g. Citizen of What 115	
	death	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?			dispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-		merican Indian,
36	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Medical Exaninat must be rediffed at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ₺No If Yes, Give		1 ☐ Yes 2√2 No		rican, etc.)	Specify:	hite, etc.
21215-0036	tural'		3 Nidowed 4 Divorced 15. Decedent's Ec	Year or Dates:	16a. Dece	dent's Usual Occup	pation	10	Sb. Kind of Busine	ss/Industry
215	within 72 ene. than "ne	Completed	(Specify only highest gra		(Give	kind of work done DO NOT use retired	during most of worki d)	ing		,
	ygiene ygiene yer tha	Соп	/2			Home	MAICE			home.
Maryland	d be filed ntal Hyg ed othe	Be c	17. Father's Name (First, Middle, Last)	Ruser			18. Mother's Name	(First, Middle, Ma	aiden Sumame) Tour	63
ary	d 2 should the and Ment of is marked traumatic	၉	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street	and Number or Rura	A PA		/
	and 2 alth a 127 is er trau		LAWRIND MAGRIA	Pen InSo.	N 3306	ORCA	Não Ave	nue B.	altimon	2 MD 21214.
Baltimore,	ges 1 and t of Healt If Item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	2		natory or other plac	ce)		c. Location - City	1
ţ	Pa nen ant: ury		' 4 □ Donation 5 □ Other (Specify 21. Signature of Fu ral Service Licen)	Dayview	CREMATO	my Africa	11, 2005 1	1/+ mar	2 Mary LAND
Ba	permit. Departr Imports any inj		21. Styrature of the law envice Licent	566	7	HARTLEY 1527	MILLER - HARFORD K	CAD BA	HIMER.	MD 21234
			shock or heart fallure. List only	olications that caused the one cause on each line.	death. Do not ent	er the mode of dyin	ng, such as cardiac c	or respiratory arres	t,	Approximate Interval Between Onset and Death
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	Examiner			Due to (or as a	,	levo vi				20 1000
	₽ ≅	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co						00 1000
	ate be executed hysician and the burial-transit	Exami	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a co	neaguages of):					
8760,	ate be ex hysician the burial			Due to (or as a co	ilisequence or).					
9	ate hy:	edic		d,						
Вох	death certific e attending p id for use as f	an/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pour 1 ☐ Live birth 2 ☐		Ectopic pregnancy	,		23d. Date of	*
Б	at the dea by the at tached fo	Physicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time 9□Unknown		Other (specify)			Month	Day Year
<u>α</u>	s that the ned by a detact	by Ph	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
Vital Records,	w requires that been signed b should be dete							1 □ Yes	2 XNO 3 🗆	Probably 4 Unknown
ecc	aw as b 2 sl	ompleted						24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
al R		Con						performe 1 Yes 2	death death 1 □ Y	? es 2□ No
Vit.	Physician: This certificatal director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ★ No	Hospital:	2 ☐ ER/Outpatier	Oth	26. Place of Death	Part Control	- 504	
of		P .	27. Manner of Peath	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	28b. Time of	t 3 DOA 28c. Injur	y at	ne Residen 28d. Describe how		респу)
sior	Attending I r death. ector: After by the funer	atlo	1 Natural 5 Pending investigation		an) Injury		Yes 2 □No			
Division	P dig ⊑	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office	2	28f. Location (Stre City or Town,		Rural Route Number,
	Ho H t H h Hely	edical C	29a. Certifier (Check only one) Medicel Exem	ysician: To the best of mainer: On the basis of exa	y knowledge, death mination and/or in	occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, date	se(s) and manner and place, and c	as stated. lue to the cause(s)
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•	\sim		The same				44604		7/11/15	
ga a	18		30. Ame and ad res on On On One	mpleted cause of death	(Item 23a) (Type,	Print)	4 Br	MMORE	MD	21234
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2	2005 32. Revistrar's 3	Signature	fork				(4

			1- State of Maryland / Department of Health and M Certificate of Death		iene 005	12384
	Dhueisi		1. Decedent's Name (First, Middle, Last)	2. Date of Deat	h Day Yea	3. Time of Death
	Physici /Medio		Agnes L. Murphy	APRIL	11 200	
	Examin	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of De	ath
			ST. HGNES HEALTHCARE DALTHORE		n/a	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	1000	irthplace (State or Foreign Country)
			218-14-0448 81 Yrs. 81 Usual Residence of Decedent	Dec 7,	1923 N	Maryland
	hours after death with the Maryland tural; or Items 23a or 28e-f show Examiner must be notified at		10a. State 10b. County 10c. City, Town or Location	-		10d. Inside City Limits
	e-f s	tor	Maryland Baltimore Catonsville			1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number 10f. Zip Code	10	0g. Citîzen of What 0	Country?
	23a	al	713 Maiden Choice Lane Apt. 2205 #2 21228		Unite	d States
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
36	ours after death with the Marylan al', or Items 23a or 28e-f show Exa niner must be notified at	by Fu	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 1 No Specify:	, ,	Specify: W	
Ö	72 hours "natural', diesi Exe		3 Wildwed 4 Divolced Year or Dates:			
5	d within 72 ho piene, r then "natur ine Medical	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workir life. DO NOT use retired)	ng	16b. Kind of Busines	s/Industry
712	I within iene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) 11 O desk clerk		telephone	company
ğ	Hyg than	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, N	Maiden Sumame)	
Maryland 21215-0036	d be and a be a be a be a be a be a be a be a b	To B	William A. Murphy Carrie A	. Hardv	•	
ary	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural			Zip Code MD 21228
	and 2 lealth m 27 I		Carolyn J. Schoeneman - sister 713 Maiden Choice Lane	Apt. 22	05 Bldg.	2,Catonsville
ore	— T @ ←		Cemetery, crematory or other place)		20c. Location - City of	
Ē	T He		1 New Cathedral Cemetery 4/1.	5/05 E	Baltimore,	Maryland
Baltimore,	permit. Departm Importa any nju		21. Signature Funeral Service Licensee 22. Name and Address of Facility Hub			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cadse on each line.			Approximate Interval Between
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	/Medical		resulting in death) Due to (or as a consequence of):	IN DI		W/YK/WWW
	Examiner		Somether list and littles ATRIAL FIBRILLATION			UNKNOUN
	be sit	inel	Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
to	and and I-tran	Examin	resulting in death) Last Due to (or as a consequence of):			
8760,	death certificate be executed e attending physician and od for use as the burial-transit	a E				
687	icate phys s the	dicai	d	* *		
	leath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	alivan
Вох	death a atter	Physician/M	in the past 12 months? 1 Ves 2 No 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
0	that the ded by the detached	hys	9 ☐ Unknown			
۳,	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Ď	w require been sig should b	ed	CONGESTIVE HEART FAILURE	1 □ Ye	s 2□No 3□F	Probably 4 Unknown
OC	e law requ has been je 2 shoul	ompleted		24a. Was an		autopsy findings available completion of cause of
Vital Records,	The ate h page	Com		perform	ned? death?	
ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner? 26. Place of Death			
	y si	은	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom		nce 6 Other (Sp.	ecify)
n O	ing P	inol.	1 Natural 5 Pending (Month, Day Year) Injury Work?	8d. Describe ho	w injury occurred	
Sic	Attanding r death. ector: After by the funer	icat	2 Accident investigation M 1 Yes 2 No	04 1		
Division of	or A after Direction by	ertification;	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town,	eet and Number or F , State)	Ru <i>rai H</i> oute Number,
	e Hospital or Attanding F 24 hours after death. a Funaral Director: After etely filled in by the funer.	O	29a. Certifier Check cold. Ch	nd due to the ca	use(s) and manner a	s stated
	e Ho 24 h a Fui	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	d at the time, da	te and place, and du	e to the cause(s)
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Me	29b. Signature and vittle of certifier 1 29c. License number	29	d. Date signed (Mon	th, Day, Year)
	1		P18606	,	APRIL 1	1 2005
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AJJAI ALVA, 900 CATON AVENUE, BALTIMORE	MD	21229	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 1 2 2005 Serve & Species	,	<u> </u>	

			For State Registrar	State of M	-	partment of H ertificate of I			ene 005	12385
	Physicia		Decedent's Name (First, Middle, Last) Richard M.					2. Date of Death Month	Day Year // 2005	3. Time of Death 9:40 AM
)	/Medic Examin		4a. Facility Name (If not institution, give	HEAL	THCARE		Location of Death		4c. County of Death	A
	Funeral Director			7. Aç	ge (In yrs. last birthda 80 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JAN 27,	1925 Ne	nplace (State or Foreign untry) WYork
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltim	ore	10c. City, Town or	Location Catonsvill	Le			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the 3a or 28	al Dire	10e. Street and Number 38 Holmehurst Ave	nue		10f. Zip Code	21228	10	og, Citizen of What Co USA	untry?
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland II of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-f show or other treumatic event, Itel Medical Evantral retrount to rotified at	by Funeral Director	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	?	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14 Race - Amer Black, White Specify: W	
21215-0036	within 72 hou ene. then "nature is Medical E	Completed	15. Decedent's Education (Specify only highest grad		5+) (Gi	cedent's Usual Occup ve kind of work done o b. DO NOT use retired	during most of work	ing	Steel Inc	•
N	id be filed ental Hygic ked other ic event,	To Be Co	17. Father's Name (First, Middle, Last) Richard Merrick				18. Mother's Name	e (First, Middle, M McCarthy		
Maryland	d 2 should the and Mark	Ė	19a. Informant's Name/Relationship (7) Cecelia Merrick/wi			iling Address <i>(Street</i> Holmehurst			City or Town, State, 2	
Baltimore, I	permil. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injury or other freumatic event, it and once.		20a. Method of Disposition 1 Burial 2 Geremation 3 F 4 Donation 5 Other (Specify)		20c. Location - City or					
Balti	permil. Pa Departmer Importenti any injury		21. Signature of Funeral Service Licens Thomas Gr	of Mary 1 Baltin	land, Inc.	1228				
	Priysician /Medical Examiner	Je.	23a. Part1. Enter the disease, or composhock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a Due to (or as	line.	NONARY PMEU				Approximate Interval Between Onset and Death B
8760, 4	cate be executed physician and the burial-transit	dical Examiner	it any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	s a consequence of):					w i
.O. Box 6	the death certifi by the attending I ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) □	,		23d. Date of deli Month	very Day Year
rds, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions co	ntributing to death	but not resulting in th	e underlying cause giv	en in Part I.	23e. Did tob	oacco use contribute to	the cause of death? obably 4 □Unknown
I Records,	The law ate has b	Completed						24a. Was ar autops perform 1 Yes 2	y prior to death?	topsy findings available completion of cause of
Vital	ician: certific	Be	25. Was case referred to medical examiner?	Hospital:	ient 2□ER/Outpa	tient 3 DOA Oth		th (Check only one	e) nnce 6	cifv)
Division of	ling Ph 1. After th funeral	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D		e of 28c. Injur			w injury occurred	,,
Divis	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	njury · At ho <i>m</i> e, farm, atc. <i>(Specify)</i>	street, factory, office		28f. Location (St. City or Town	reet and Number or Ru n, State)	ıral Route Number,
	e Hospi 124 hour e Funer letely fill	Medical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the bes iner: On the basis and manners	of examination and/o	eath occurred at the tir r investigation, in my o	me, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	10.	70	29c. Licens	18619		9d. Date signed (Monti	h, Day, Year)
,	+ 11		30. Name and address of person who co	62en ompleted cause of	death (Item 23a) (Ty	pe, Print)	10011	/	MYKIL, 1	1 2005
	671		ISMAILA JIB, 31. Date filed (Month, Day, Year)	RIM, S	T, AGN trar's Signature	ES HEA	LTHCAR	E, 90	70 S. CA7	ON AVE.
	Sta Regist	ate rar		R 1 2 200	15 Kenn	. K how	all I			

			For State Registrar	State of Mar	yland		rtment of H				giene Reg. No.	005	12386
			Decedent's Name (First, Middle, Last	st)					2	. Date of Dea	ath	V	3. Time of Death
	Physicia			Joan Eager	Mac	Kie				April	8. 20	Year	12:36 PM
	/Medid Examin		4a. Facility Name (If not institution, give		1100		4b. City, Town, or	Location	of Death		4c. Co	ounty of Death	
			Hospice of Baltim	ore:Gilchr	ist (Center	Tows	on				timore	County
	Funeral		5. Social Security Number 6. S	ex 7. Age (☐ M 25∑ F		st birthday)	If Under 1 Year Months Days	If Under Hours	Min.	. Date of Birt (Month, Da)	y, Year)	Coui	
	Director	-	216-20-0889 Usual Residence of Decedent	X.	82	Yrs.			1	lug 14	, 1922	2 Mar	y1and
	land	1	10a. State 10b, County	1	10c. City,	Town or Loc	cation						IOd. Inside City Limits
	Mary I sh	to	Maryland Baltimon	ce County		Тс	wson						1 ☐ Yes 2√ No
	r 28a	Director	10e. Street and Number	e courty i			10f. Zip Code				10g. Citize	n of What Cou	ntry?
	th wit	aD	1055 W. Joppa Ro	ad			21:	204				USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Or ın, Mexica	rigin? (Spec n, Puerto Ri	fy Yes or No- can, etc.)	. 14	. Race - Ameri Black, White,	
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show is Medical Exercities mast be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:)	1	☐ Yes 2X No	Specify.	:		S	oecify: W	nite
21215-0036	hour	ed b	15. Decedent's Ed	L		16a. Deced	ent's Usual Occup	ation			16b. Kind	of Business/In	dustry
15	in 72 n "ne Nedis	Completed	(Specify only highest gra			(Give	kind of work done o OO NOT use retired	during mos	st of working	7			
212	d with giene or tha	E O	Elementary/Secondary (0-12)	4 yrs		Н	omemaker				Own	Reside	ence
b	al Hy r othe	ВеС	17. Father's Name (First, Middle, Last)					18. Moth	er's Name (First, Middle,	Maiden Su	ımame)	
Maryland	Ment Ment arkec	2	Auville	Eager								r Murra	
Mar	2 short and is m		19a. Informant's Name/Relationship (g Address (Street				-		
6	l and lealth im 27 her ti		Sally M. Lynch 20a. Method of Disposition	(Daughter			Essex Sti	reet,	Squa			chusett	
Jor	in of the state of		1 ☐ Burial 2 【X*Cremation 3 ☐		cer	netery, cren	natory or other plac						
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exercitest intail the notified at ODGs.	1	*4 □ Donation 5 □ Other (Specification of Funeral), ervice the	1	Gree		int Cemet						Maryland
Ba	permi Depa Impo any ir		I COUCHI OC	wson			Name and Address itcheII-						
			23a. Part1. Enter the disease, or com	plications that caused the	he death.	Do not ente	500 York or the mode of dyin	-KOAQ ig, such as	s cardiac or	C1MOTE respiratory ar	rest,	yrang /	Approximate Interval Between
	Priysician	C 10	shock, or heart failure. List only Immediate Cause (Final	one cause on each line									Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or as a	conseque	ence of):							W-12
r	Examiner		Sequentially list conditions	b									
	D E	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	ence of):							
6	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	conseque	ance of):							
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	aE			001100400	31.00 01,1							
687	phys phys s the	dical		_ d									
Box (leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							230	d. Date of deliv	ery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 2 4□Pregnant at ti			Ectopic pregnancy Other <i>(specify)</i> _					Month	Day Year
P.0	t the	hys	9 Unknowh	9□ Unknown									
S, F		by F	Part II. Other significant conditions	contributing to death but	not result	ting in the ur	nderlying cause giv	en in Part	1.				he cause of death?
ord	v requires been sign should be	ted								<u> </u>	Yes 2		
Record	aw 1s b	Completed								24a. Was autor			opsy findings available empletion of cause of
A F	That are page									1 Tes	2 X/No	1 ☐ Yes	2 □ No
of Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:			Oth			<i>(Check only c</i> e 5 ☐ Resid		Corpor (Consi	whospice
of		-	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient		R/Outpatien 28b. Time of	28c. Injur	y at		d. Describe I			y) v cospice
lon	Attending P st death. ector: After I by the funera	atlor	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	Year)	Injury	M 1 🗆	K? Yes 2 ☐	No				
Division	l or Attendi after death. Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		y - At hon	ne, farm, str	eet, factory, office		28	If. Location (S		Number or Rur	al Route Number,
	tal or	Cert		Donaing, etc.									
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical		nysician: To the best of miner: On the basis of e and manner state	examination								
	To the h within 2 To the f complete	Mec	29b. Signature and title of certifier	and manner state	o u.		29c. Licens	e number			29d. Date	signed (Month,	Day, Year)
	ک∓≩ټ			1 m)		D 59	303			APPLIC	, R A	200
	10		30. N e and address of person who	completed cause of de			Print)				. 01[[V 4
	10		AARON J. CHAR	us mo	660		Charle	12 2	- Dal	Ltuno	e mi	> < 120	4
	Sta		31. Date filed (Month, Day, Year)	32. Registra 1 2 2005	Signatu	ure Le	1.11	,					,
	Regist	rar	APR	LZ 4UUS A	low	می ر	Made						

DHMH 17 Rev 1/2001

04.08 2005

State of Maryland / Department of Health and Mental Hygiene

							Cer	rtifica	te of	Death		Rag. N	o.	UU	16-	001
			1. Decedent's Name (First, Middle	e, Last)							2. Date of			Vana	3. Time o	f Death
	Physici		- 1 20 1 mmls								Month	1 9.	•	Year	1:58	PM
	/Medic		Louise Motsch 4a. Facility Name (If not institution						1	4b. City, Town, or	Apri Location of De		c. County of			
	Examir	ıer		-						D-1+2			D-1+4			
			Oak Crest Care 5. Social Security Number	6. Sex		(In vrs la	st birthday)	If Und	er 1 Year	Baltimo If Under 24 Hrs	S. 8 Date of	Birth	Balti		ace (State of	or Foreian
	Funeral				₽ F	85	Yrs.	Months	Days	Hours Mir		Day, Year			'ry)	
	Director		218-03-1032 Usual Residence of Decedent			0.5					06/	19/19	19	MD		
	and and		10a. State 10b. County			10c. City	Town or Lo	cation						10	od. Inside C	ity Limits
	sho	ក													1 🗆 Yes	2 X No
7	Pe 88 € 1	ect		Arund	el	Gle	n Bur		ip Code			100 C	itizen of W	hat Count	trv?	
7	ight of the	늅	10e. Street and Number					101. 2	ip Code			10g. 0	1112011 01 44	nat cour		
3	ath v	ra.	933 Langley Ro	ad					1060				ited	Stat - America		
3	eb ne de	une	11. Marital Status	12. W	as Decedent E med Forces?	ever in U,S	5. 13. V	was Dec f Yes, sp	ecify Cub	Hispanic Origin? (an, Mexican, Pue	specity tes or nto Rican, etc.)	No-		k, White,		
10	S effe	×	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 [☐ Yes 2X N Yes, Give	lo		1 🗆 Yes	2X No	Specify:			Specify:			
Motschied	21215-0020 4 within 72 hours efter death with the Maryland giene. Fithen "neturel", or ltems 23a or 28e4 show the Madical Examiner must be notified at	Completed by Funeral Director			ear or Dates:		10- D					10h I	Vind of Du	Whi		
Š	72 12 12 12 12 12 12 12 12 12 12 12 12 12	ete	15. Deceden (Specify only highes	t's Education st grade com	n pleted)		16a. Deced	kind of w	vork done	during most of wo d)	orking		Kind of Bus		_	
+	2 9 9 ji	ם	Elementary/Secondary (0-12)	Co	ollege (1-4or 5-	+)	me. L	DONOI	256 /6(i/6	<i>u)</i>		Sw	reeth	eart	Paper	
2	d 2.	ပိ	12	(Secr	etar	У	18. Mother's Na	mo (Eirot Mid		mpan			
5	be fill H dot	a	17. Father's Name (First, Middle,	Last)						16. Motter's Na	illie (First, Mild	uie, iviaiue	ii Sumame	9)		
111	arylan should be and Mental s marked o umatic ev	ို	Alexander Eis								Cesky					
U	IOTE, Maryland 21215-0020 ges 1 end 2 should be filed within 72 hours efter death with the Marylan to f Health end Mental Hygiene. If them 27 is marked other then "neturel", or items 23a or 28e-1 show or other traumatic event, the Madical Examiner must be notified at		19a. Informant's Name/Relations				19b. Mailir	ng Addre	ss (Street	t and Number or F	Rural Route Nu	mber, City	or Town, S	State, Zip	Code)	
	end salth		Laura Smith/Gr	andda	aughte		933	Lang	gley	Road Gle						
X	PS 1 PS 1 PS 1 PS 1 PS 1 PS 1 PS 1 PS 1		20a. Method of Disposition 1 ☐ Burial 2 🖟 Cremation	2 □Bomov	ral from State	20b. Pla	ace of Dispo metery, crer	isition (N matory oi	ame of r other pla	ice)	Date		_ocation - (City or To	wn, State	
íś.	Pages vent of I		4 □ Donation 5 □ Other (S		arron state	Ch	esapes	iko (Crema	torv	Apr 1 2005	Be	ltsvi	lle,	Maryl	and
(구 하루 무슨		21. Signature of Funeral Service	Licensee	110 h		22			ess of Facility					17	
	Bal permi any ir		1/4	1.11	NO	0980	1			and Fune						a
			23a. Part1. Enter the disease, or	complication	ns that caused	the death				n Pasture			CIMOI	e, Ma	Approximat	te
	Disconistant		shock, or heart failure. List	only one cau	use on each lin	10.								į	Intervel Bei Onset and	ween Death
	Physician /Medical		Immediate Cause (Final				0 . 1			١.				į		
	Examiner		disease or condition resulting in death)	a	My	o ca	roial	, ,	vte	rchor	1					
		<u></u>	*		1 \	Due to (or	as e conseq	fneuce o	f): "	eart d	~			į		
	15 eg //	Examiner		6 b.—						eart o	150as	6				
	ox 68760, Conflicate be executed indig physician end ise as the buriel-transit	xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			Due to (or	as a conseq	uence of	f):							
	68760, tificate be exent of physician eras the buriel-		Cause (Disease or injury	c												
	87 cate phys	Medicai	that initiated events resulting in death) Last		[Due to (or	as a conseq	uence of	·):							
	certifish	ş		d				417								
	o e de de de de de de de de de de de de d	/sic	Part II. Othar algnificant condition	ns contributi	ing to death bu	ıt not resu	Iting in the u	nderlying	cause gi	ven in Part I.			-		tha causa	
	P.C	Physicia	Acuto 1	1.200	1 fai	luc	P				1	☐ Yaa	2 4NO	3 Prob	ably 4	Unknown
	es the bed	Completed by		21.00	, For	() (0.41- 14/-		fin dia no
	ould	<u>ş</u>	Fig.								24a. W	/as an auto erformed?	opsy	ava	re autopsy alable prior	to
	aw range of the same of the sa	pie.												of c	npletion of death?	2000
	The Ist	E									1	☐ Yes 2	2440	1 🗆]Yes 2□] No
	tor, p	Bec	25. Was case referred to medica							26. Place of De	eath (Check or	ly one)				
	s cer	10 E	examiner? 1 ☐ Yes 2 ☑ No	Hospita	al: 1 🗌 Inpatie	nt 2 🗆 E	R/Outpatier	nt 3□ [DOA Ot	her: 4 Mursing	Home 5□R	esidence	6 □Othe	r (Specify)	
	Phy erel	2	27. Manner of Death	28	a. Date of Injur (Month, Day	y Voar)	28b. Time of Injury	f	28c. Inju Wo	ry at	.28d. Descri	be how inj	ury occurre	ed		
	oding th. : Afte	읉	1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident investi		(Nonin, Day	7 7007)	injury	М		Yes 2□No						
	Division of Vital Records, P.O. Be or Attending Physician: The law requires that the deeth efter death. Jinector: After this certificate has been signed by the ettel in by the funerel director, page 2 should be detached for its by the funerel director, page 2.	<u>=</u>	3 ☐ Suicide 6 ☐ Could determ	not be	e. Place of Inju	ıry - At ho	me, farm, str	eet, facto	ory, office		28f. Locatio	n (Street a Town, Sta	ind Numbe	er or Rura	Route Nun	nber,
	d age d	Certification:	4 Homicide		building, etc	:. (Зрвспу,	,				Only or	rown, old	.07			
	spita nours nerai		29a. Certifier 1 Certifyin	g Physician	: To the best o	of my know	rledge, death	n occurre	d at the ti	me, date and place	e, end due to	he cause(s) and mar	ner as st	ated.	
	Division of Vital Records, P.O. Be to the Hospital or Attending Physician: The law requires that the deeth within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ette completely filled in by the funeral director, page 2 should be detached for	Medicai	(Check only 2 ☐ Medical one)	Examinar: C	On the basis of and manner sta	examinati	on and/or in	vestigatio	on, in my	opinion, death occ	curred at the tir	ne, date ar	nd place, a	nd due to	tne cause(5)
	omp omp	Me	29b. Signature and title of certifie	r				2	9c. Licen	se number		29d. D	ate signed	(Month, I	Day, Year)	
	->-0		Dan mo	-12-	> m	0			Dec.	16 V 1=		Apr	110	11	200	_
	1X		30. Name and address of person				23a) (Tyne	Print\	W > 8	1646		7 80	, 1	11		>
	7 \		4						Ω	k. 11.	in :	217:	2 U			
	0.0		Anna Monics 31. Date filed (Month, Day, Year)	8800	32. Registra	ar's Sialat	ure	or ro	P'CL!	kv:11e	10()	, ~	-			
	Sta Regist	ate rar			2 2005	10-	and a	K.	4000	W						

			For State Registrar	State of Maryland / De	partmen <i>ertificat</i>			nd Me		iene g. No.	05	12388
			1. Decedent's Name (First, Middle, L	ast)	******			2.	Date of Deat	h Day	Year	3. Time of Death
	Physici /Medio		Fred .	J. McGreevy				A	pril	7	2005	11:45A M
}	Examin		4a. Fecility Name (If not institution, gi	ve street and number)	4b. City,	Town, or	Location of	Death		4c. Co	unty of Death	
			5360 Eliot's Oal			Colum		711 - 1		I	loward	
	Funeral			Sex 7. Age (In yrs. last birtho	Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,	Year)	Cou	place (State or Foreign intry)
	Director		119-24-1012 Usual Residence of Decedent	72 Yrs				ļ M	lay 11,	1932	New	York
	/land		10a. State 10b. County	10c. City, Town o	r Location							10d. Inside City Limits
	Man	to	Maryland Howard	d Col	umbia							1 ☐ Yes 2 🖾 No
	r 28g	Director	10e. Street and Number		10f. Zip	Code			10	0g. Citizen	of What Cou	intry?
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show than "houldal Examiliar installs motilliad at	al D	5360 Eliot's Oal	k Road		2	1044			U.	S.A.	
	dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	3. Was Dece	dent of His	spanic Origin	in? (Specif	y Yes or No-		Race - Ameri Black, White	
36	or It		1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☆Yes 2 □ No If Yes, Give Korean Year or Dates:	1 ☐ Yes			, 00110 1 110	, στσ.,		noife	
8	ural',	d by	3 Widowed 4 Divorced								wn:	
5	"nat	Completed	15. Decedent's E (Specify only highest g	rade completed) (C	ecedent's Usua live kind of wo le. DO NOT u	rk done di	u <i>rina most</i> o	of working		16b. Kind o	of Business/Ir	ndustry
2	within ene. than	d L	Elementary/Secondary (0-12)	College (1-4or 5+)	stom's	,				י דו	Gover	mant
0	filed Hygi other	C	17. Father's Name (First, Middle, Las		3 0 0111			s Name (F	irst, Middle, N			imerie
au	lid be lental ked ic ev	To Be	Edward McGreevy				Jose	ephin	e Rice			
Maryland 21215-0036	shou and M a mar umat	_	19a. Informant's Name/Relationship	(Type, Print) 19b. M	ailing Address	(Street a	nd Number	or Rural R	oute Number,	City or To	wn, State, Zi	c Code)
Σ	alth alth a 127 is		Arleen McGreevy	(Wife) 536) Eliot	's 0	ak Ro	ad C	columbi	a, Ma	rylano	1 21044
ore	of He of He roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	20b. Place of Di cemetery,	sposition (Nar	ne of ther place)	Date	2	20c. Locati	on - City or T	own, State
Ĕ	Pag ment ant: Il ury o		`4 □Donation 5 □ Other (Spec		a Memo	rial	Pk 4	4-12-	2005 (Clark	sville	, Maryland
Baltimore,	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, I'lls Modical Exacilities nail be notified at ance.		21. Signature of Funeral Service Lice	C C	22. Name an	d Address	of Facility	Homes	, Inc.			To the
_	80589		M praybo	Lectura	5555 1	win	Kno11:	s Roa	d Col		, Mary	land 21045
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death. Do not y one cause on each line.	enter the mod		1	,	espiratory arre	st,		Approximate Interval Between Onset and Death
4	Priyaician		Immediate Cause (Final disease or condition	a. acute my	ocarles	1	in tar	etron				1 Clay
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	/							1 2000
		-	Sequentially list conditions,	b. Due to (or as a consequence of).	ille							1 1 600
	ted nsit	Examiner	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury	In the laction	Monon	don't	di	chelen	rovel	11.60		IS YELL
/	s be executed sician and burial-transit	xai	that initiated events resulting in death) Last	C. Due to (or as a consequence of):	9010.			~	1 000	1103		0 / 000 0
8760,	ate be executed hysician and the burial-transit	dical		a gratherosclero	W2							Chos
Ö	tificate g physi as the b	ledk		V								
Вох	death certifica e attending ph ed for use as t	N/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pr	оппалсу				23d.	Date of deliv	,
		sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of death	5 Other (sp						Month	Day Year
P.O.	that the de ed by the detached	Physiclan/Me	9 Unknown									
	es ign be	by	Part II. Other significant conditions	contributing to death but not resulting in th	e underlying c	ause give	n in Part I.			accouse d s 2 □ N		he cause of death?
orc	w requir been s should	eted								5 Z 🗆 NI		pably 4 Unknown
Vital Records,	has b	Completed							24a. Was an autopsy perform	/	b. Were auto prior to co death?	opsy findings available impletion of cause of
al F									1 Yes 2	No	1 Yes	2 □ No
<u> </u>	Physician: this certificanal director, I	Be c	25. Was case referred to medical examiner?	Hospital:					heck only one	7		
oţ	Physic ruthis aral di	To To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b. Tim		Bc. Injury Work	4 ∐ Nursi		5 Resider			(y)
O	th. Afte	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Inju	У		? es 2 □ No	0		. ,		
Division of	Attandi r death. actor: A by the fu	ifica	3 Suicide 6 Could not determined	286. Place of Injury - At nome, farm	street, factory	, office		28f.			ımber or Rur	al Route Number,
Ö	al or A s after al Dira	Certification:	4 Hornicide	building, etc. (Specify)					City or Town,	State)		
	To the Hospital or Attanding Physician: white 24 hours after deals. To the Funaral Director: After this certification of the funaral director, to ompletely filled in by the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director, the funeral director director director, the funeral director	-	29a. Certifier 1 Certifying P	hysician: To the best of my knowledge, d miner: On the basis of examination and/o	eath occurred	at the time	e, date and p	place, and	due to the ca	use(s) and	manner as s	stated.
	the H iin 24 the Fi	ledical	ona)	and manner stated.								
	To To con	Σ	29b. Signature and title of certifier	10/2	-	. License	- 0 -		29	d. Date sig	ned (Month,	Day, Year)
7	10		· / len	y Truces MP		1)	266	21		Apri	17	, 2005
	(0		30. Name and address of person who	completed cause of death (Item 23a) (Ty MI) 10 700 Chr 32. Registrar's Signature	pe, Print)		Slimi	hin	MA	. 229	2.10	F\$
	Sta	te	31. Date filed (Month, Day, Year)	:32. Registrar's Signature		1.1	20				- 10	
	Registr		ATP	R 1 2 2005 Blown	S. A	TO SE						

			For Stata Registrar	State o	f Marylan		artment rtificate			Mental H	/giene	UU.	5	12389
P	Physici	an	1. Decedent's Name (First, Middle, La		101-			,		2. Date of D	Da		Year	3. Time of Death
	/Medic Examir	cal	THELMA— 4a. Facility Name (If not institution, gi	MOR/ re street and nur			4b. City, T	own, or Loc	cation of Dea	April	0.5	. County o	OOS Death	10157 1 M
	Lydillit		HARBOR HOSP	ITAL	CENTE	R		KTIN	ORE			-		PORE
	Funeral Director			Sex 1□M 2X1F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months		Under 24 Hr lours Mir		irth	45	9. Birthpl Count	ace (State or Foreign
	'g		Usual Residence of Decedent			_								
	Manylar f show	JO.	10a. State 10b. County	1.1		, Town or Lo							10	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	h the h	Director	Md Anne Ar	undel	GIG	an bur	10f. Zip 0	Code			10g. Ci	tizen of W	hat Count	try?
	ath wit		217 Warfield	Road				.060				SA		
980	n 72 hours after death with the Maryland "natural", or items 23s or 28a-f show edical Evantuar must be invitined at	by Funeral	11. Marital Status 1 ↑ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed Fo 1 Tyes If Yes, Giv Year or Da	2 X No		Was Decede fYes, specif 1 ☐ Yes 2	_	inic Origin? (Mexican, Pue <i>pecify:</i>	Specify Yes or N rto Rican, etc.)	0-		- America k, White, e	etc.
5-0	72 ho 'natur	eted	15. Decedent's E (Specify only highest gi	ducation ade completed)		(Give	dent's Usual kind of work	done durin	n ng most of w	orking	16b. K	ind of Bus	siness/Ind	ustry
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Ma	d 2 7 is		19a. Informant's Name/Relationship John Hall - Sot				_{lg Address (} Warfie			Ru <i>ral R</i> oute <i>Num.</i> Len Buri				Code)
ore,	- T a =		20a. Method of Disposition 1 XBurial 2 Cremation 3	Domayal from 1		lace of Dispo	sition (Name	of	1	Date	20c. L	ocation - C	City or Tov	wn, State
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Ba	permit. Departr Importa any inji	, 1	21. Signature of Funeral Service Lice	nsee	() 22				larch F/l enue Ba			2121	5
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on e	aused the death	. Do not ent						ilu		Approximate Interval Between
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E	Examiner	<u></u>	Sequentially list conditions,	A C	OTE	REN	AL_	FAI (URE			AUST		MONTHS
Ξ	cuted id ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•	IEUMOR									ONE WEEK
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68760,	ficate t physics to the b	edical		_d	tssive		BES17	7						YEARS
O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live b	come of pregnal irth 2 Petal ant at time of de own	death 3	Ectopic pred Other (spec					23d. Date Mont		y Day Year
S, D	res that igned b	by Pi	Part II. Other significant conditions				nderlying cau	ise given in	Part I.	23e. Did	tobacco	use contrib	oute to the	e cause of death?
ord	law requires that the as been signed by th 2 should be detache		DIABE		MELLI-					1 🗆	Yes 2	□No 3	Proba	ibly 4 □Unknown
Vital Record	m — m	Completed	CORON	<u> </u>	ARTE		DISE			24a. Wa auto perf		pri	ior to com ath?	sy findings available pletion of cause of
ital	ian: The rtificate stor, pag	Be Co	Con GES 25. Was case referred to medical	71VC F	1 EART	FAI	LURE		. Place of De	1 ☐ Yes	2/2No	1	Yes 2	2 No
of V	Physician: this certific	2	examiner?	-	patient 2 🗆 E			Appropriate the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section is a second section of the second section of the second section is a second section of the section of the section of	4 ☐ Nursing	Home 5 ☐ Res				
ou (ding F h. After funera	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		of Injury h, Day Year)	28b. Time of Injury	M 280	i. Injury at Work? 1 □ Yes	2 🗆 No	28d. Describe	how inju	ry occurred	d	
Division	al or Attanding s after death. il Director: After ad in by the fune	Certification:	3 Suicide 6 Could not I 4 Homicide determined	28e. Place	of Injury - At hong, etc. (Specify	me, farm, str		7 7		28f. Location City or To			r or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1 Cartifying P (Check only one) 2 Madicel Exa	nysician: To the minar: On the ba and mann	asis of examinat	vledge, death ion and/or inv	occurred at	the time, d	late and place on, death occ	e, and due to the surred at the time	cause(s) , date and	and mani place, an	ner as sta nd due to t	ited. the cause(s)
	with To	Σ	29b. Signature and title of certifier					PQA		718		te signed (NOVER ST.
) Sta	te	30. Name and address of person who MILENA Garage 31. Date filed (Month, Day, Year)	EBSKA	- MAI	RBOR	$n\omega$	PICA	C CE	NTER	BA	LTIM	OCE	NOVER ST., 140 21225
	Registr	1	App :	9 2005	egistrar's Signat	J.	Mar	1						
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ORIGINAL

State of Maryland / Department of Health and Mental Hygierie 🛭 🗎 5 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1545 PM APRII /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 12,1940 Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2 F Yrs Director 373-40-8698 64 Michigan Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ahov ust be rictified at 1 ☐ Yes 2 No Directo Columbia Maryland Howard the 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō 9490 Dawnblush Court Items 23g U.S.A. 21045 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No IfYes, Give Vietnam Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status other traumatic event, the Medical Evantual to filed within 72 hours after 1 ☐ Never Married 25 Married ō Baltimore, Maryland 21215-0036 β 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Specify "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 ia marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 5+ Psychiatrist Medica1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Earl Tuttle May 2 Marjorie Rathbun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 ia n any injury or other traun Elizabeth May (Wife) 9490 Dawnblush Ct. Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 4-14-2005 Beltsville, Maryland 21. Signature of Fundan Service Linenses 22. Name and Address of Facility once. Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DISSEMINATED INTRAVASCULAR COAGULATION le HOURS disease or condition resulting in death) /Medical Examiner PSEUDOMONAL BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Box 68760 Physician/Medicai the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy The law requires that the death for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4° Conknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2 🗆 No 1 Yes 2 🗆 No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 2 No Other: 1 🗌 Yes 1 X Inpatient 2 2 ER/Outpatient 3 DOA $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After t 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 | Homicide within 24 hours after To the Funeral Differential Differential Differential Differential Differential Differential Differential Differential Differential Differential Differential Differential Differential Differential D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier, 29d. Date signed (Month, Day, Year) RES-000 Million ? wil Name and address of person who completed cause of death (Item 23a) (Type, Print) GONDHIH WOLFE STREET JOHNO HOPKIND HOSPITAL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

amend item#4a, 10e, 19b, perrit, 10b, 1642, 4/12/05 Tr.
State of Maryland / Department of Health and Mental Hygiene 1- State Registra Amend Item #5 PerFH C848 10/18976 if care of Death Reg. No. 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) April 06,2005 **Physician** 6:59 pm MARY AUDREY MILLER /Medical 4a. Facility Name (If not institution, give street and number)
932 Sunny Brook
932 Orive 4c. County of Death 4b. City, Town, or Location of Death Examiner Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) al Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Sect. 218-12-**Funeral** 1□M 20 F Yrs. Director Maryland Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City. Town or Location 10a. State r than "natural", or Items 23a or 28a-f show Ite Medical Examiner must be notified at 1 ☐ Yes 2 🗷 No Glen Burnie Director Maryland Anne Arundel 10e. Street and Number Brook 932 Sunny brook Drive 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21060 death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. be filed within 72 hours after d tal Hygiene. d other than "natural", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ۾ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8 0 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fits Department of Health and Mental Hinportant: If Item 27 is marked oth any injury or other traumatic event once. Frank Ruff A. Dressel Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 932 Sunny Brook 1 Prive, Glen Burnie, Maryland 21060 in Miller (Daughter Phyllis Law) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04-09-05 Cedar Hill Cem. Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
237 East Patapsco Avenue, Baltimore, 21. Signature of Funeral Service Licensee 21225 my Maryland an Approximate Interval Between Onset and Death 233 Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SIndron Physician MHELOCYSPIONTE disease or condition resulting in death) /Medical Due to (or as a conseque ce of). 1-1/2 year Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Iner attending physician and for use as the burial-transit law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, as been signe 2 should be d þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an severe autopsy performed? Yes 2 1 Yes 2 No certificate 1 ☐ Yes Division of Vital Within 24 hours after death.

To the Funeral Director: After this certific Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 1 ☐ Yes 2 📈 Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🔀 ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

A and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatule M.D D0060842 4.8.5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. HANOVER ST. BALTIMORE MD 21230 PAREKH VAIBHAY A. 1147 31. Date filed (Month, Day, Year) . Registrar's Signature State APR 1 2 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year DR. GEORGE LEONARD MCCARGO JR. APRIL /Medical 11 2005 0035 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death MARYLAN GENERAL HOSPITAL BALTIMORE CITY NIA 6. Sex 1 🔼 M 2 🗆 F Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, AUG: 18 Birthplace (State or Foreign Country) 217-30-4042 9 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 le marked other then "naturel", or items 23a or 28a-1 ehow other traumatic event, the Medical Examinat mast be notified at 10d. Inside City Limits Completed by Funeral Director 1 AYes 2 No MARVIAND NIA 10e. Street and Number 10g. Citizen of What Country? BERT STREET 121 Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
item 27 le marked other then "naturel; or ite. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: BLAC 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HIGRADE ONTRACTOR SELF-EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be LEONARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 JOSEPHINE SISTER) 620 BELLEVIEU AVE. BALTHORE, MAZIZIS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 10 = 10 1. Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. NATIONAL CEME 04-16-05 LAUREL, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address 21. Signature of Funeral Service Licensee of Facility BROWN JR. FULTON AVE. 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Die o (or as a consequence o /Medical **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? Director: After 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 X Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) OCME APRIL 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE DOOREM, King 111 Penn Street Baltimore, Maryland 21201 3 Registrar's Signature Date filed (Month, Day, Year) State 2 2005 Registrar 1

		1 - For Stete Registrar		of Marylan		artment rtificate					giene Reg. No.	UJ		2393)
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Exami		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, 7	own, or	Location of			4c.	County of I	Death		
		Anne Arundel	Medical	Center			apol				I	Anne A	lrun	del	
Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 64		If Under	Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9.	Birthpl: Count	ace (State or F	oreign
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d within 72 hours after death with the Maryland yiene, rithan "natural", or Items 23a or 28a-f show the Maulical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces	s? TNo		Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		14. Race - Ar Black, W	merican Indian, Thite, etc. White	
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	dical Examiner	Sequentially list conditions, if any, leading to immediate the conditions of the con	b. Due to (or a											
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7		30. Name and address of person with	no completed cause of	death (Item	23a) (Type,	Print)	MAR	TEK 7) K	#200	Cou	Umkio	1003	net et
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for State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day John William McBurnette III 1:35 A M Cupril 5 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore
If Under 1 Year If Under 24 Hrs.
Hours Min. University Specialty HOSDITO. 1 **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Jan 13, 1943 Birthplace (State or Foreign Country) Days Months 1₩ 2□F 217-40-0289 Director 62 Yrs MD Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at MD Completed by Funeral Director Anne Arundel Glen Burnie 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 114 Governors Court, Apt. C items 23a 21061 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced "natural", white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7: th and Mental Hygiene. 7 is marked othar than "n. Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Shop Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John W. McBurnette, Jr. Melba Hazel Hartsock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an item 27 Mrs. Beverly A. McBurnette/wife 114 Governors Court, Apt. C, Glen Burnie, MD 21061 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State = 5 permit. Page Department of important: if any injury or once. `4 ☐Donation 5 ☐ Other (Specify) Meadowridge Memorial Apr.9,2005 Elkridge, MD 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Juneral Service L Second Avenue S.W., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiac armythemiois 15 minules /Medical Due to (or as a consequence of): Examiner heam - disease 5 425 Othero scientic Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diahotes mellitus End 3 ☐ Probably 4 ☐ Unknown stage penal disease Completed 1 ☐ Yes 2 ☐ No on Hemodialysis Commany orteny diseuse 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No Chronie chstrictive disease Vent dependent 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death, investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hou. the Funaral Directory 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the within 2 To the 29b. Signature and title of certifier To I 29c. License number 29d. Date signed (Month, Day, Year) D36494 4-5-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gel south chales St Balhmore movikes KNESAIMO University speciffy taspital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🛭 🕦 💍 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 9:45 A M Middleton Roger 2005 /Medical April 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chever1v Prince Georges Prince George Hospital Center If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ☑ M 2 ☐ F Hours Director 450-68-8145 61 Jan 25, Texas 1944 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Eurer is a process. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Bladensburg 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6011 Emerson Street 20710 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Completed by Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales/Painter Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jesel Unobtainable В. 2 Middleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 W 39th Street Indianapolis IN 46208 Marilyn L. Middleton 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 [Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 4/11/05 Brentwood, MD 21. Signature of Funeral Service Comsee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Unknown Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 4☐Pregnant at time of death page 2 should be detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Be Completed Lung Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 AUnknown Stroke 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 Yes 2 X No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Director; After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

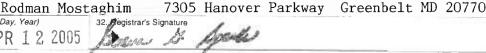
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) APR 1 2 2005

2003

30. Name and address of person who feeted cause of death (Item 23a) (Type, Print)



D 46093

4/8/05

with the Maryland 10b. County 10c. City, Town or Location 7 is markad other than "naturel", or items 23e or 28a-f show traumatic event, the Medical Examirar must ke notified at Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 South Market Street 21078 USA death 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. o filed within 72 hours after I Hygiene. other then "naturel", or Ite 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Co-Owner/ Operator Appliance Store permit. Pages 1 and 2 should be file. Department of Health and Mental Hyg Important: If item 271s marked other eny injury or other traum... 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Andrew J. Boggs Nettie March 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Cagney Court, Bel Air, Maryland 21014
ce of Disposition (Name of Date 20c. Location City or Town, State Steven V. Miller - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 DBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Mem. Gardens 1 4/11/05 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. Bel Air, Maryland Bel Air Mem. Gardens 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 Mercers 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Proysician metastatic Cancer unknown /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ rheu matica 1 ☐ Yes Completed Melletz, 24a. Was an autopsy performed? Atnal Tibrillation 1 Yes 28 No of Vital To the Hospital or Attending Physicien: To the Funerel Diractor: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Division 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funerel Diractor: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide

1. Decedent's Name (First, Middle, Last)

"itizens

5. Social Security Number

216-09-2231

Usual Residence of Decedent

Ruth

4a. Facility Name (If not institution, give street and number)

Miller

Home

7. Age (In yrs. last birthday)

89

Nursino

1 ☐ M 2 🛣 F

6. Sex

Physician

/Medical

Examiner

Funeral

Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death

4b, City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs. Months Days Hours Min.

tavre De Groce

2. Date of Death

April

8. Date of Birth (Month, Day, Year)

0

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 □ No

7.55 A M

Year

2005

Hartord

18, 1915 West Virginia

Black, White, etc.

White

Simmons

Approximate Interval Between Onset and Death

7 days

4c. County of Death

29a. Certifier

29b. Signature and title of certifier

Prashant

31. Date filed (Month, Day, Year)

APR 1 2 2005

Shukla

Medical

State

Registrar

			1 - For State Registrar		epartment of Health and Certificate of Death	Mental Hygie	2005 12348
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici		CATHERING ELIZA	BETH MOORE		Month 04 08 -	2005 Year 2:38 AM
}	/Medic Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Dea		4c. County of Death
			STELLA MARIS AT	MERCY	BALTIMORE		NA
	Funeral Director		FF0 · 30 · 6001	M 2 F 7. Age (In yrs. last birthe	Months Days Hours Min		ar) 9. Birthplace (State or Foreign Country) MD
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location		10d, Inside City Limits
	Maryl f sho	ō	MO BALTIMO	RE GWYNN	OAK		1 ☐ Yes 2(A) No
	r 28e	Director	10e. Street and Number	CD GIOTAIO	10f. Zip Code	10g.	Citizen of What Country?
	h with		1689 LANFORD RD		21207		USA
	ems S	Funeral			13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show say injury or other treumetic event, its Madical Examinar must be notified at ance.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	1000, 000,	Specify: BLACK
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121	vithin ne. han	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	ife. DO NOT use retired)		and anor
2	filed v Hygie ther t		17. Father's Name (First, Middle, Last)	NA	LPN 18 Mother's Na	me (First, Middle, Maid	EALTH CARE
an	iould be filed within I Mental Hygiene. Parked other than netic event, ILEM	o Be	HARRY C . MACKEY			FIELDS	ien Suname,
Maryland	2 should be filed and Mental Hygis le marked other eumetic event, II	To	19a. Informant's Name/Relationship (Typ	pe, Print) 19b. N	Mailing Address (Street and Number or R		y or Town, State, Zip Code)
	t and 2 Health a em 27 le ther treu		DONNA L. WESTON	168	21215000 00 0	UYNN OAK	MD 21207
J.	of Hei of Hei fitem r othe		20a. Method of Disposition	comotoni	risposition (Name of crematory or other place)		Location - City or Town, State
Ë	Pages ment of I ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro `4 ☐ Donation 5 ☐ Other (Specify)	mo NA	MONAL 04.	4.05 LA	UREL, MD
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service License	I	22. Name and Address of Facility VAUGHN C. GREENE F. 5151 BALTO. NATC PIKE	UNERAL SER	VICE 1D 21229
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do not			Approximate Interval Between
	Physician.		Immediate Cause (Final disease or condition	the state of the s	mother congr		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of)			
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Вох	leath certifii attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	dc. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of delivery
	The law requires that the death centifue has been signed by the attending tage? I should be detached for use an	Physician/Mo	1 Yes 2 No	4 Pregnant at time of death 9 Unknown	5 Other (specify)		Month Day Year
P.0	res that the igned by be detac		Part II. Other significant conditions con	tributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobaco	o use contribute to the cause of death?
Vital Records,	uires sign ld be	d by				1 ☐ Yes	2 No 3 Probably 4 Unknown
CO	w require been si should?	iete				24a. Was an	24b. Were autopsy findings available
Re	The lay	Completed				autopsy performed	prior to completion of cause of death?
ta		a	25. Was case referred to medical		26. Place of De	1 ☐ Yes 2 ☐ ath Check onlone	Ño 1 ☐ Yes 2 ☐ No
\	di d	To B	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2 ER/Outpa	atient 3 DOA Other: 4 Nursing H	Home 5 ☐ Residence	6 Defer (Specify) SALLE
n of	ding Ph h. After th funeral	:uo	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28b. Tim (Month, Day Year) Inju	ne of 28c. Injury at	28d. Describe how in	ury occurred
Sio	tendine eath.	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No		
Division	or At	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	pritel		29a. Certifier Certifying Phys	ician: To the best of my knowledge of	leath occurred at the time, date and place	and due to the source	(4) and managed as about
	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the funera	edicai	(Check only 2 Medicel Examin	er: On the basis of examination and/o and manner stated.	or investigation, in my opinion, death occu	urred at the time, date a	and place, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
	1		> yr has		D4085	4	4/11/2005
10	0		30. Name and address of person who		ppe, Print) So) St (m) (1	Onidoner	21202
V	Sta	to	31. Date filed (Month, Day, Year)			C west downers.	-
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			For State Registrar	State of Ma			rtment of H tificate of L		nd M		giene Reg. No.	005	12399
			1. Decedent's Name (First, Middle, La	st)						2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Roosevelt H. Mu	ınson]	March		2005	1:00 AM
	Examin		4a. Facility Name (If not institution, giv-	street and number)			4b. Cîty, Town, or	Location of I	Death		4c.	County of Dea	th
			Joseph Ritchie				Baltimo	ore					
H	Funeral		5. Social Security Number 6. S		(In yrs. last birti	hday)	If Under 1 Year Months Days		Hrs. Min,	8. Date of Bir (Month, Da	th v. Year)	9. Bin	thplace (State or Foreign
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	anyla shov	_	Toa. State										1X Yes 2 □ No
	8e-f	Sct	MD		Balti	mor	T				40- 00		-1.0
	vith ti		10e. Street and Number				10f. Zip Code					zen of What Co	ountry?
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212-0036	72 hours after death with the Maryland "netural", or Items 23e or 28e-f show oldal Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Mivorced	12. Was Decedent E- Armed Forces? 1 Yes 20 No If Yes, Give Year or Dates:		i	/as Decedent of Hi Yes, specify Cuba □ Yes 2XNo	Specify:	Puerto F	Rican, etc.)		Black, White	te, etc.
Ž	2 hou	ted	15. Decedent's E	ducation	16a.	Deced	ent's Usual Occupa	ation	A wheir		16b. Kir	nd of Business	/Industry
2	hin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. D	ind of work done of O NDT use retired	during most o	WORKIE	ig			
7	filed within Hygiene, ther than "	Ю	5th			ick	mason				Con	struct	tion
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<u> </u>		2	George Munson					Evel:	lyn	Munso	on		
Maryland	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing	g Address (Street a	and Number	or Rura	l Route Numb	er, Cîty or	Town, State,	Zip Code)
	rt 2		Roy Munson Sr.	(Brother			old Mil				Co.	21207	7
Baltimore,	of Hee		20a. Method of Disposition 1 Xaurial 2 Cremation 3	Bamayal from State	20b. Place of cemeter	Dispos y, crem	ition (Name of atory or other plac	e)	D	ate	20c. Lo	cation - City or	Town, State
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I Records,	The law requires that the sete has been signed by the page 2 should be detache	Completed				<u>-</u> .			_	24a. Was auto perfo			utopsy findings available completion of cause of
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ō	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certification in the funeral director, the funeral director, and the funeral director.	2	1 Yes 2000 27. Manne Death 1 atural 5 Pending	1 ☐ Inpatien 28a. Date of Injung (Month, Day	28b. T	tpatient Time of njury	28c. Injun Worl	y at k?	2	ne 5 ☐ Resi 28d. Describe		occurred	HOGICO
Division	r Attend ter death irector: /	ertification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e Jac Blace of Injur		rm, stre		Yes 2 □ No	-	28f. Location (City or To	Street and wn, State)	d Number or Ri	ural Route Number,
	spitei o nours afi nere! Di y filled ir	O	29a. Certifier 1 2 ertifying Pt	ysician: To the best o	f my knowledge	, death	occurred at the tim	ne, date and	place, a	and due to the	cause(s)	and manner as	s stated.
	the Hc the Fu the Fu	Medical	one)	niner: On the basis of and manner stat		a/or inv	estigation, in my o		occurre	ed at the time,		place, and due e signed (M)	
,	vit. To		29b. Signature and title of certifier	alme	MI		The state of the s	30%	2		4/	1/2	5
			30. Name and address of pareon who	2 43/1	and	Туре, Р	Print)	THE	12	31/10		1/1/2	128
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05-023 UNKNOW WHM	34 ROBE	RT	For Amend Item 1				lelible Ink. E			-	12400
	_		Registrar 1. Decedent's Name (First, Middle, La	st)			inicate of De		2. Date of Death		3. Time of Death
	Physici /Medio		ROBERT L.	MCLENO	ON .	JR.			APRIL 2		10:32 P ^M
	Examin	er	4a. Facility Name (If not institution, giv JOHNS HOPKINS HO				4b. City, Town, or Loc BALTIMORE			4c. County of Dea	n A
5413	Funeral Director		5. Social Security Number 6. S 212 · 60 · 8251 Usual Residence of Decedent	-	e (In yrs. last b 51	irthday) Yrs.		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day,) 02 - 10 - 10	(ear) , Co	thplace (State or Foreign buntry)
	ryland how		10a. State 10b. County		10c. City, To						10d. Inside City Limits
	h the Marylan r 28a-f show notified at	ecto	MD N (9	BALTI	MOR	10f. Zip Code		100	g. Citizen of What Co	1 🖽 Yes 2 No
	h with 23a or 3	Funeral Director	3920 KENYON	AVE.			21213		1.0	USA	
	er deal	uner	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💢		13. W	as Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Specexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
036	ours aft ral', or Exami	l by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	10	1	Yes 20 No Sp	ecify:		Specify: BL	ACK
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212	be filed within 72 hours after death with the Maryland ital Hygiene. of other than "natural", or items 23s or 28s-f show svent, the Modical Exeminer must be notified at	Completed	Elementary/Secondary (0-12) 12 TH GRADE	College (1-4or 5	i+)		CHANIC			BELF EM	PLOYED
Maryland 21215-0036	d 2 should be filed within 72 hours after death with the th and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or 28 traumatic svent, the Medical Examiner must be not	To Be (17. Father's Name (First, Middle, Last, ROBERT MCLEN)					Mother's Name	(First, Middle, Ma	aiden Surname) ORE	
lary	2 shou and M Is mar	-	19a. Informant's Name/Relationship (19	b. Mailing	Address (Street and I				01007
	1 and Health tem 27		20a. Method of Disposition	ENDON	20b. Place	of Dispos	ST. AGNES		CATONS!	Oc. Location - City or	
altimore,	Pages nent of ant: If i		1 ⊠Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif		WEST	ERN	atory or other place)	04-11		BALTIMOQ	
Balt	permit. Pages 1 and 2 should be Departnent of Health and Menta Important: If item 27 Is marked any injury or other traumatic sv QDCs.		21. Signature of Funeral Service Licer	1500		v#1	Name and Address of	Facility EENE F	UNERAL	SERVICE MD 212	29
3760,	bhysician the death certificate be executed Wedined by the attending physician and detached for use as the burial-transit	Ilcal Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as		in and and and and and and and and and an	nd Cocaine)				Onset and Death
P.O. Box 68760,	The law requires that the death certificate be exe ate has been signed by the attending physician a page 2 should be detached for use as the burial-I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ds, P.	ires that signed by d be deta	by	Part II. Other significant conditions of	contributing to death b	ut not resulting	in the un	derlying cause given in	Part I.			o the cause of death?
COL	aw require s been si 2 should b	Completed							24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
l Re	The law ate has page 2 s	Com							performed 1 X Yes 2	ed? death?	
Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ∑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 V7 ER/O	utnationt	Othor		(Check only one	ce 6 Other (Spe	acifu)
n of	iding Phys Ih. After this (funeral dir	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injui (Month, Day		Time of Injury	28c. Injury at Work?		8d. Describe how		unk
Division of Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident 3 Suicide 4 Homicide 2 Accident Galactic investigation G	7 2 03	9:1 ury - At home, f c. (Specify)		M 1 Yes	2	8f. Location (Stre City or Town,	et and Number of B State) 1700 b	ural Route Number, LOCK OI
	Hospita 4 hours Funeral	edical C	(Check only 2X Medicel Exer	ysicien: To the best on niner: On the basis of	of my knowledg examination a	ge, death nd/or inve	occurred at the time, do	ate and place, a	nd due to the cau	ise(s) and manner a	s stated.
_	To the Hos within 24 h To the Fun completely	Med	29b. Signature and tille of certifier	and manner sta	N A		29c. License nur	nber	296	d. Date signed (Moni	th, Day, Year)
	9		SHA	1//	V _	_	OCME		A	PRIL 3, 20	005
U	2		30. Name and address of person who	completed dause of d	eath (Item 23a)	(Туре, Р		Street	Baltimo	ore, Maryl	and 21201
*	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 20	32 Aegistra	ar's Signature	Son	de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 20b per fb 842 4-19-05 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 64 **Physician** 07 KEITH MOURE Jais /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMAL MD Ka. ea 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, **Funeral** 1**X**M 2□F Days Hours Min 41 Yrs Director North Usual Residence of Decedent the Maryland 10c. City. Town or Location 10b. County 10a State 10d. Inside City Limits 7 ie marked other then "natural", or Items 23a or 28a-f shov treumatic event, the Medical Exame ar must be cylified at 1 X Yes 2 □ No Director Maryland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours atter death with 1 nent of Heatth and Mental Hygiene. Int: If Item 27 ie marked other then "natural", or Items 23a or? 1SA 21215 € Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hele 2 unk. 19a. Informant's Name/Relationship (Type, Print) Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Lemetery, crematory or other place) curtment of Health a creant: if item 27 le GWINN 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) arame 21. Signature of Funeral Service Cicensee Dep mp any Funeral It Home Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock Immediate Cause (Final AIDS Priyaician PINSNUSIS Feb 2003 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** eresul toxoplasmosis 18 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) bec 1 ☐ Yes 2 ☐ No by the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Contitos C 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 2 🗆 No 1 Yes 1 Yes or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 10 this After thi funeral 28d. Describe how injury occurred 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation in by the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier D 0036954 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. UNINSTS PRUS BALTIMAN MAD 21318 WAYNE 201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MD

Robber

CAMPSELL

2005

APR 12

32. Registrar's signature

			For State Registrer	State of M	aryland	-		of Health a of Death	and M		giene Reg. No.	005	12402
	0		1. Decedent's Name (First, Middle, Las	t)						2. Date of Dea		Vear	3. Time of Death
	Physici /Medio		Doris Eve	lyn N	agel					April	07 07	2005	5:00 PM
	Examir		4a. Facility Name (If not institution, give	street and number	")			wn, or Location of	of Death			ounty of Death	
			Locust Lodge					sadena				nne Aru	
	Funeral		5. Social Security Number 6. Se	ox 7. A □M 2 🔀 F	ge (In yrs. Ia: 0.6	st birthday) Yrs.	If Under 1 Y Months D	ear If Under:	Min.	8. Date of Birt _(Month, Day Jan.	h Y Year)	9. Birthp	nlace (State or Foreign htry) WVA
Ш	Director		219-05-9431 1Usual Residence of Decedent		86	113.				Jan. A	21 19	19	WVA
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	Marylan -f show fled at	ģ	MD Anne Aru	nde1	Pasa	adena							1 ☐ Yes 2 🕱 No
	r 28a	irec	10e. Street and Number				10f. Zip Co	ode			10g. Citize	n of What Cour	ntry?
	23a o	Funeral Director	874 Turf Valley	Drive			2	1122			US.	A	
	deal	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	. 13.	Was Decedent	of Hispanic Orig Cuban, Mexican	gin? (Spe	cify Yes or No-	- 14.	Race - Americ Black, White,	
98	or It	J.	1 Never Married 2 Married	1 ∐Yes 2 🔀 If Yes, Give	No	1	1 ☐ Yes 2 🏻		,	,			ite
21215-0036	72 hours after death with the Maryland Ineturel, or Items 23a or 28a-1 show digel Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	:	100 D							
5	"net	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		(Give	lent's Usual O kind of work d DO NOT use n	iccupation lone during most etired)	t of workir	ng	16b. Kind	of Business/In	dustry
7	filed within Hygiene. other then " ent, De Mei	mc duc	Elementary/Secondary (0-12)	College (1-4or	5+)		emaker	J J. Z.			Ноц	sehold	
9	Hygi Sther ent,		17. Father's Name (First, Middle, Last)		1		marco	18. Mothe	r's Name	(First, Middle,			
Maryland	2 should be f and Mental H Is marked of sumatic eve	To Be	Samuel R. Willia	mson				B1 a	anche	Strou	t		
ary	shound M		19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailin	g Address (Si	treet and Numbe	r or Rura	Route Numbe	r, City or To	own, State, Zip	Code)
	ウモトラ		Kenneth W. Nagel,	Sr.		917 1	1th St	reet Pas	sader	na. MD	21122		
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Ramoval from State	cer	ce of Dispo	sition (Name on atory or other	of	D	ate	20c. Locat	tion - City or To	wn, State
** Meadowridge Mem. Park 4/11/2005 Elkr							Elkr	idge, M	D				
Ball	Therefore V The Secretary Flouritain Ru. Pasagena. Mil 71177							e, P.A.					
		23a, Part 1. Enter the disease or complications that caused the death. By not enter the mode of dying, such as cardiac or respiratory arrest, Approximate							Approximate				
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final							Onset and Death			
	/Medical		disease or condition resulting in death)	Due to (or a	s a conseque		1101						
	Examiner		Sequentially list conditions	b									
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%	and and I-trans	хаш	that initiated events resulting in death) Last	c. Due to (or a)	s a conseque	nce of):							
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687	ficate g phys is the	edic		0									
Вох	leath certifica attending ph i for use as th	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			N=+:-				23d	. Date of delive	ery
œ.	death	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 No	4 □ Pregnant a			Ectopic pregn Other (specif					Month	Day Year
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ord	w require been signature	ted	Alzheimers	Atrial		illat				1 🗆 Y	es 2/10 N	10 3 F100	ably 4 DUnknown
Vital Records,	e law has b	Completed	Pulmonary	Edema	Hy	per	upide	mia		24a. Was a autop	sy		psy findings available appletion of cause of
		Cor	Anemia							perfor 1 Yes	2 No	1 Yes	2 🗆 No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other		(Check only or		.31	A > > 1 1 1
of	Phys r this ral dii	. To	1 Yes 2 No	1 ∐ Inpat 28a. Date of Inj	ient 2 El	R/Outpatien 8b. Time of		Injury at		ne 5 ∐ Resid 8d. Describe h) Assisted him
on	th. : After s funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D.	ay Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ N	No				
Division	Attending or death. ector: After by the funer	flice	3 ☐ Suicide 6 ☐ Could not be determined	289. Place of Ir		e, farm, str	et, factory, of	fice	2	8f. Location (S City or Tow	treet and N	umber or Rura	l Route Number,
Ö	itel or rs afte rel Dir	Certification;	4 Normalia	building, e	etc. (Specify)					Ony or You	n, State)		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the besiner: On the basis and manner s	of examinatio	edge, death n and/or inv	occurred at the restigation, in	he time, date and my opinion, deat	d place, a th occurre	nd due to the d d at the time, d	ause(s) and late and pla	d manner as st ace, and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier					cense number		2		igned (Month, i	Day, Year)
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	6		30. Name and address of person who c	completed cause of	death (Item 2	23a) (Type,	Print)	i , i "I	Pasa	da	400	21122	
			Candau Chandle	1 20 76	Edwir	1 1400	nor B	10 d. 1		SUTO	<i></i>		
	Sta Registr		APR 12 2	005	Land Signate	× 1	cools						
	State Registrar 31. Date filed (Month Par Year) 2 2005 32. Registrar's Signature												

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Rita F. Nolan April 2005 8. 2:30_PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Baltimore** Stella Maris Nursing Home Timonium | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. (Month, Day, Year) | March 1, 1919 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 📆 🖼 F 212-12-6398 86 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner bust be notified at Baltimore Timonium Maryland 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2300 Dulaney Valley Road USA 21093 or itama 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 200 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 White 1 Yes 2000 Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerical Insurance Company 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event <u>once</u>. 17. Father's Name (First, Middle, Last) John F. Nolan Mary Hughes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2411 Garrett Road White Hall, MD 21161 Mary P. Streeter Niece Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MXBurial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 4/12/05 Baltimore, Maryland ¹ 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signalu e of Funeral Service Licenses 3631 Falls Road, Baltimore, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each me. Approximate Interval Between Onset and Death « Grafie Immediate Cause (Final 1/05 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 200 1 Tyes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2210 Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospitat or Attending Pl 24 hours after death. Funeral Director: After the Certification: Metural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide 24 hours a The sartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Market Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number -05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDTE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM 21093 EDDIE NAKHUDA, M.D. 31. Date filed (Month, Day, Year) APR 1 2 2005 32. Registrar's Signature State

Registrar

2005

8

APRIL

NOLAN, RITA

amend item#8, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death April 10 **Physician** Emma Lucretia Ogg 7:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Long View Nursing Home Manchester If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1909 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 216-03-9801 1 ☐ M 2 ☐ F 95 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show The Medical Exprimer must be notified at Manchester 1 Yes 2 No Maryland Carroll Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3008 Bachman Rd. 21102 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specity: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Seamstress Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item Z7 is marked other any injury or other traumatic event Ques. Be Horatio George Edward Stoffle Bessic Mae Yingling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda Black - Grand daughter 3106 Maiden Lane, Manchester, Md. 21102 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Johns Church Cem. April 13,2005 Westminster, Md. 1 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, Md. 21102 21. Signature of Funeral Service Licensee Elsku 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each jule. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Examiner Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2∏ No 1 Yes 2 🗷 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Cther: 1 ☐ Yes 2 🕱 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier nd address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

filed within 72 hours after death with the Maryland

is marked other than

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

use as the burial-tran the attending physician and

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After 1

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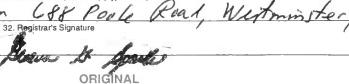
To the Hospital o within 24 hours eff To the Funeral Di

completely filled in by the funeral director,

or Attending Physician:

Im W. Model wton

31. Date filed (Month, Day, Year)



		For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F rtificate of		Mental Hy	giene ()5	12405
		Decedent's Name (First, Middle, Last)		-			2. Date of De	aath		3. Time of Death
Physici		WALTER OVERSTREET	1				APCIL	6,20	Year	6:28PM
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea			ty of Death	
		North Arunde.	1 HOSPI	101	61en	Burni	e	And	le A	rundel
Funeral Director		5. Social Security Number 6. Sec. 428.76.5894	7. Ag X 2□ F	64 Yrs.	Months Days	Hours Mir	n. (Month, Da	th ay, Year) .,1941	9. Birth	place (State or Foreign Intry) MS
D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d, Inside City Limits
anyle ho	5			100. 0.0, 101 0, 2	out or					1 ☐ Yes 2 ☐ No
28a-f	Director	MD ANNE ARU 10e. Street and Number	NDEL		10f. Zip Code	PASAD	DENA	10g. Citizen of	f What Cou	mtrv?
with a se	흐	7793 OUTING RD				122		USA		HAS
death ma 2;	era	· · · · · · · · · · · · · · · · · · ·	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H		(Specify Yes or No		ace - Amer	ican Indian,
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heath and Mental hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Fores 2 1 Yes 2 1 If Yes, Give Year or Dates:	40	1 ☐ Yes 2 ☐ No	an, Mexican, Pue Specify:	erto Hican, etc.)	Spec	ack, White ify: WH]	
Maryland 21215-0036 d 2 should be filed within 72 hours eff th and Mental Hyglene. It is marked other than "natural", or treumatic event, the Medical Exami	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	edent's Usual Occur e kind of work done	during most of w	rorking	16b. Kind of		
Mary Mark	de l	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retire	·				
tygler th		17. Father's Name (First, Middle, Last)		MI	EAT PACKE		ame (First, Middle			CESSING
and d be find he ad of	Be c	SAMUEL OVERSTREET					ER MAE TH		iiio)	
ryli hould mark matic	은	19a. Informant's Name/Relationship (Ty		19h Mail	ing Address (Street				n State Zi	in Code)
Manual treum		JACQUE LAFLEUR	po, 7 mm,		2 HOLLIDA			•	.,	, ,
Heal Heal tem 2		20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date Date	20c. Location	- City or T	own, State
TO ages ant of it: If I		XXBurial 2 ☐ Cremation 3XX 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	MT. CAVA	matory or other pla	1	0.2005	EUNICE	T A	
altimore, mit. Pages 1 a parment of Hes portant: If Item y injury or othe		21. Signature of Funeral Service Licens	99		ARYLAND N			EUNICE	, 1.11	
Depa Impo Impo any i		K. GREGORY FYN	K	MO1148 4	26 CRAIN	HWY SW	GLEN BUR	NIE,MD	21061	
Physician /Medical		23a. Part. Enter the disease, of complished, or heart failure. List only of Immediate Sause (Final disease or condition resulting in death)	Acute	Myelo			ac or respiratory a			Approximate Interval Between Onset and Death
Examiner	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. September 10 (of as	a consequence of): a consequence of): a consequence of):	oek.					Hars
BOX 6 death certif e attending d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{M} \) No 9 \(\subseteq \text{Unknown} \)	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			Date of deliveration	very Day Year
Records, P.O. he law requires that the s has been signed by th ige 2 should be detache	þ	Part II. Other significant conditions col	ntributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.		tobacco use co		the cause of death?
Cord: Iw require s been sis should to	Completed	-					24a. Was		. Were aut	opsy findings available
Vital Rec slcien: The law s certificate has t lirector, page 2 s	Juo						auto	psy ormed? 2 X-No	death?	ompletion of cause of 2 No
tal en:] tifficat tor. pi	d)	25. Was case referred to medical				26. Place of D	leath (Check only		163	Z
ysici ysici is cer direc	To B	examiner? 1 Tyes 3/2 No	lospital: Impatie	ent 2 ER/Outpatie	nt 3 DOA Ot	nor.	Home 5 ☐ Res		ther (Spec	ify)
On O		27. Manner of Death 1 ★ Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry y Year) 28b. Time Injury	Wo	ry at rk?]Yes 2 □ No	28d Describe	how injury occu	urred	
Division of Vital Re to the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, s c. (Specify)	treet, factory, office			(Street and Nun wn, State)	nber or Rui	ral Route Number,
Me Hospitei n 24 hours : ne Funerel	edical (of my knowledge, dea f examination and/or i ated.						
To the Hawithin 24 To the Fu	W	29b. Signature and title of centifier	10, 1	4.D.	29c. Licens D01	se number	14	29d. Date sign	led (Month	2005
3/1		30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Type	, Print)	210	Clanos	Boni	101	10 20161
Sta	te	31. Date filed (Month, Day, Year)	200 Registr	ar's Signature	posts	-JVC	ale/ III	20171		11/20141

overstieet, walter

			1 - State Registrar	State of Maryland / De	partment of Health and ertificate of Death		ene2005 12406
ï	Physicia	an	Decedent's Name (First, Middle, Last			2. Date of Death Month	3. Time of Death
	/Medic	al .	Joyce T. 4a. Facility Name (If not institution, give	3 ' Shea	4b. City, Town, or Location of D	April 12	, 2005 5:45 A M
	Examin	er	Keswick Nursi		Baltimore C		N/A
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24 I		9. Birthplace (State or Foreign Country)
	Director		244-40-9332	M 200xF 74 Yrs	World S Days 110d/s	Nov. 13,	1930 North Carolina
	and bw		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Mary -f sho	tor	Md. Balti	more	Baltimore		1 ☐ Yes 2 No
	n the	Director	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Country?
	23a c	alD	6451 North Char	les St. Apt. 354	21212		USA
00	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or Items 23a or 23a-f show importent: If item 27 is marked other then "natural", or Items 23a or 23a-f show importent: It items 23a or 23a-f show importent if items 2 inclined at an once.	by Funeral	11. Marital Status 1 ☐ Never Married 2☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Pe 1 ☐ Yes 2 ☒ No Specify: 	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
2	tural		15. Decedent's Edi	ucation 16a. De	cedent's Usual Occupation	16	b. Kind of Business/Industry
2	hin 72 3. 3n "ng Media	ompleted	(Specify only highest grad	(G College (1-4or 5+)	ive kind of work done during most of a. DO NOT use retired)	working	
7	ed wit	Соп			. of Church Hospi		Medicine
2	be fill	Be	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle, Ma	
Š	should nd Men marke umatic	L _o	Ephram Tui 19a. Informant's Name/Relationship (T	CKET	ailing Address (Street and Number o		npson
D N	Ith an 27 is r		Mrs. Amy Minter/Ni	741			n, Pennsylvania 15068
nore,	Pages 1 ar		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify,	20b. Place of Di cemetery, o	sposition (Name of crematory or other place)	Date 20	Oc. Location - City or Town, State
	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licens	Daixwood	the state of the s		oncord, North Carolina o Funeral Home, Inc.
Ď	permi Depa Impo any is		Muchael	1 Rugh	1050 York Road		Marvland 21204
	1		23a. Part1. Enter the disease, or course shock, or heart failure. List only control of the contr	ications that cau d the death. Do not ne cause on each line.	enter the mode of dying, such as car	diac or respiratory arres	t, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Sc	Lemic Bde	vel DIS	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consquence of):			
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):			
	uted d ansit	Examiner	Cause (Disease or injury that initiated events				
ć	an an		resulting in death) Last	Due to (or as a consequence of):	-		
00/0	cate be executed physician and the burial-transit	dlcal		d			
0	ding p	/Mec	IF FEMALE:	23c. If yes, outcome of pregnancy			and Day of the last
DOX	death certifi e attending id for use as	Physiclan/Me	in the past 12 months?		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
j.	the d by the ached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown			
as, r	The law requires that the death certific tte has been signed by the attending f age 2 should be detached for use as	by P	Part II. Other significant conditions co	ntributing to death but not resulting in th	e underlying cause given in Part I.		cco use contribute to the cause of death?
	equir een si ould					1 ☐ Yes	2∰No 3 Probably 4 Unknown
Lecor	: The law I cate has b page 2 sh	ompleted				— 24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
		O				1 ☐ Yes 245	No 1 Yes 2 No
N I G		o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Othor	Death (Check only one)	ce 6 ☐Other (Specify)
õ	ding Phys n. After this funeral di	$\mathbf{F}_{\mathbf{p}}$	27. Manner of Death	28a. Date of Injury 28b. Tim	e of 28c. Injury at	28d. Describe how	
VISION	tending F death. tor: After the funer	atlo	Natural 5 Pending investigation		M 1 Yes 2 No		
<u> </u>	or Att	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
2	pitel o	O	29a, Certifier Westifying Phy	rsician: To the best of my knowledge, d	eath occurred at the time, date and n	lace, and due to the cau	co(c) and manner as stated
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical	(Check only 2 Medical Exam	iner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death o	occurred at the time, date	e and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1/1/1/1/1	29c. License number	290	I. Date signed (Month, Day, Year)
	1X	1		/www	0.2733	4	April - 12-2005
The Assessment	グ		30. Name in raddress of person who c	Toseph (Item 23a) (Ty	De, Print) DW 40H SM	reet Bal	tto 21211
e a c	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar bignature	4. Souls		

000)		State of Maryland / Department of Health and State Unpend Item 23a,27,28a-f per me 68424-09-054 tas	•	9
				1.09.	
	Physici		Decedent's Name (First, Middle, Last) REX DALE OWENS	2. Date of Death Month	Day Year
	/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of De		01, 2005 7:15p M 4c. County of Death
			339 GATEWATER COURT APT 204 GLEN BURNIE		ANNE ARUNDEL
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H Months Days Hours Mi		9. Birthplace (State or Foreign Gountty) MARY LAND
-			Usual Residence of Decedent	JUNE 0, 1	707 MAKY LAND
	lanylar show	7	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-f show	Funeral Director	MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code	10a	Citizen of What Country?
	s 23e or	ai Di	339 GATEWATER COURT APT 204 21060		USA
	after dea or Items	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
350	urs aft	by	1 Nover Married 2 Married 1 Yes 2 No		Specify: WHITE
215-0036	J within 72 hours after death with the Maryland jianu r than: It a Madical Exteriment aust be neilified at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of w	rocking 16t	b. Kind of Business/Industry
Z	within ane. than "	mpie	(Specify only highest grade completed) [Specify only highest grade completed] [Give kind of work done during most of wo	Orang	COMMERCIAL
7	filed Hygi sther	Be Co	, TATALER	ame (First, Middle, Mai	
yland	should be nd Mental i marked c	To B	JOHN F. OWENS, JR. PATSY	MARIE SCOTT	Г
Mar	ls a		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I		
a,	is 1 and of Health item 27 other tr		SUSAN PNEVMATIKATOS/SISTER 3704 COLONIAL AVENUE 20a. Method of Disposition 20b. Place of Disposition (Name of		LA, VIKGINIA 22309 C. Location - City or Town, State
Baitimor	permit. Pages Department of H Important: If ite any injury or of once.		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) 'A □ Donation 5 □ Other (Specify) 'A □ Donation 5 □ Other (Specify) 'A □ Donation 5 □ Other (Specify)		-33
Salt	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	FLECK FUNER	RAL HOME, INC.
.,	<u> </u>		23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi		REL, MARYLAND 20707
	Physician		nock, or heart failure. List only one cause on each line.	ac or respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Narcotic Intoxication Due to (or as a consequence of):	-	
	Examiner	_	Sequentially list conditions, bb.		
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
ָבֻ בַּ	e exection and and and and and and and and and an	Exa	resulting in death) Last Due to (or as a consequence of):		
00/0	death certificate be executed e attending physician and id for use as the burial-transit	edical	d		
o xoa	w requires that the death certifica been signed by the attending ph should be detached for use as th	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
-	ed for	Physician/M	in the past 12 months? 1 Yes 2 No 1 No 1 Other (specify)		Month Day Year
٦.	The law requires that the ale has been signed by the page 2 should be detache		9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tobacc	co use contribute to the cause of death?
cords,	uires l n signe	d by		1 ☐ Yes	2 No 3 Probably 4 Unknown
0 0 10	aw rec is bee 2 shou	plete		24a. Was an	24b. Were autopsy findings available
<u>-</u>	The page	Completed		autopsy performed 1 Yes 2	
\ 1 \ \ \	certification	o Be		eath (Check only one)	SCEME
5	g Physer this ieral di	- 1	27 Manner of Death 282 Date of Injury 28h Time of 282 January at	Home 5 ☐ Residence	
VISION	eath. or: Aft	catio	2 Accident investigation 2-1-05 7:08 PM 1 Yes 2 No		
2	or Att after d Direct in by	Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	and Number of Rural Route Number ate) 339 Galewater Cour
_	spitel hours inerel y filled		Found at home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.	Glen Burn	e(s) and manner as stated
	To the Hospitel or Attending Physicien: The law within 24 burus after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2:	f edical	(Check only one) 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	curred at the time, date a	and place, and due to the cause(s)
	vit to con	Σ	29b. Signature and title of certifier OCME		Date signed <i>(Month, Day, Year)</i> RIL 02, 2005
1	n		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ALI	LII 02, 200)
(7)		MARLAND B KOREL 111 Penn Stree	et Baltimor	ce, Maryland 21201
	Star Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature		
	negistra	11	APR 1 2 2005		

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	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of De	Day Vo	3. Time of Death
1	/Medic	al .	KWESI A · OWENS 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat		8, 2005	2315 P M
	Examin	er	University Hospital		Baltimor				A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th 9.	Birthplace (State or Foreign Country)
Н	Director		219.98.645 10M 20F 22	Yrs.	Miorial 5 Bays	110013	05.10.	1982	MD
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	MD NA BALT	TMOR	E				1 LYes 2 No
	or 284	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	it Country?
	s 23s	rail	3207 NORMOUNT AVE.	12.1	Vas Decedent of Hi	spanic Origin? (5	Specify Ves or No	USA 14 Bace -	American Indian,
	Iter de r Item iner n	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 12. Was Decedent Ever in U.S. Armed Forces?		Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	Black, V	White, etc.
98	ours at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		I□Yes 2∰No	Specify:		Specify: E	3LACK
5-0	be filed within 72 hours after death with the Maryland tal Hygiene d other than "naturel", or items 23a or 28a-f show avent, the Madral Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	lurina most of wo	rking	16b. Kind of Busin	ess/Industry
121	within ene. than	duc	Elementary/Secondary (0-12) OH GRADE NA	1	ORFR	,		PRINTING	2
<u>d</u> 2	e filed I Hygi other	Be C	17. Father's Name (First, Middle, Last)		014-1-	18. Mother's Na	me (First, Middle	, Maiden Sumame)	71
Maryland 21215-0036	Men Men arke	To B	MARVIN T. LEE			MONICA	,	IENS	
Man	2 sho and i		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	Address (Street a		man a second to	er, City or Town, Sta	ite, Zip Code)
e,	1 and 3 Health em 27 sther tr		MONICA L. ELLISON 20a. Method of Disposition 20b. Pla 20b. Pla	ce of Dispo	sition (Name of	of AVE.	BALTO Date	20c. Location - Cit	y or Town, State
JOE L	Pages ent of nt: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)		natory or other plac RV		14.05	RANDAUS	OM WINGE
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signatur of Funeral Service Licensee		Name and Addres			The state of the s	ing to the
8	89529		2 augh	151	51 BALTO. 1	VATC PIK	E. BALT). MD 212	
			23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dying	g, such as cardi <i>a</i>	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
1	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque	gun	shot u	sound	3		-
	Examiner			in Carony.					1
-	7 =	ner	Sequentially list conditions, if any, leading to immediate outse. Enter UT defining Cause (Disease or injury	nce of):					
	ecuter and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque	unce of):					
8760,	ficate be executed physician and sthe burial-transit		235 (0 (0) 23 2 05 (150)						
687	death certificate be executed e attending physician and nd for use as the burial-transit	edicai	d						
Вох	death certifica attending phate as to the as t	lan/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal c		Ectopic pregnancy			23d. Date o	
O. B	ie dea the att	Physicia	in the past 12 months? 1	ith 5□	Other (specify)			MONTH	Day Toal
۵.	that the de ned by the detached		Part II. Other significant conditions contributing to death but not result	ing in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use contribu	ute to the cause of death?
ds,	es De pe	d by					1 🗆	Yes 2 □ 10 3[☐ Probably 4 ☐Unknown
Record	> 4 0	piete					24a. Was		re autopsy findings available or to completion of cause of
l Re	e - e	Completed					1 X Yes	ormed? dea	
Vital	e e	Be (25. Was case referred to medical examiner?		Oth		ath (Check only	one)	
of	Phys rthis ral di	-: To	1 XXes 2 No 1 Inpatient 2 XE	R/Outpatier 28b. Time o	it 3 DOA	4 Nursing i	-	idence 6 Other (how injury occurred	(Specify)
ion	Attending in death. ector: After by the funer	ation	1 □Natural 5 □ Pending (Month, Day Y → r) 2 □ Accident investigation	a	28c. Injun Worl	<br Yes 2□No	Suk	plect 5	shot
Division	r Attendi er death. rector: A	Certification;	3 Suicide 4 Somicide 6 □ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, larm, str	eet, factory, office		28f. Location	(Street and Number of wn, State)	or Rural Route Number
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu			2	weet		30	(-1 more	MO
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only and only only only only only only only only	edge, deat on and/or in	vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time	, date and place, and	I due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License	e number		29d. Date signed (M	Vonth, Day, Year)
	/		+ tale latole	N	0.C.1	4.E.		April 9,	2005
,	M		30. Name and address of person who completed cause of teath (Item			Raltim	ore Mer	ryland 212	Ω1
d	-		14.10			, Daremi	ore, rial	yrana 212	<u> </u>
熟	Sta Regist		31. Date liled (Month, Day, Year) 32. Registrar's Signatu	Goerle					

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2005

		Plea	se Type								-		_	le.		
		For State Registrar	Stat	e of Ma	aryland		rtmen <i>tificate</i>			and N	Mental Hy	/gier Reg. R		5	12410	
Dhaminin		1. Decedent's Name (First, Middle		-		•					2. Date of D		ay	Year	3. Time of Death	
Physicia /Medica		Maynard	Peddic	ord							April		2005		8:40 PM	1
Examine		4a. Facility Name (If not institution					4b. City,		Location of	of Death		4	c. County o			
		Gilchrist Hos							owson				Balt			
Funeral Director		5. Social Security Number 219 30 2912	6. Sex XXX M 2□		e (In yrs. Ia 70	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of B (Month, D Sept 2	irth ay, Yea O,	1934	9. Birth Con Mar	place (State or Foreig intry) yland	n
and *		Usual Residence of Decedent 10a. State 10b. County			10c. City	, Town or Loc	cation								10d, Inside City Limits	
Aaryl.	ŏ	Maryland	N/A			Baltim	ore							-	XXYes 2□No	
the 28a-	ec	10e. Street and Number			l		10f. Zip	Code				10g. (Citizen of W	hat Co	intry?	_
3a or		3604 Keswick	Road					21	211				USA			
death me 2	Funeral Director	11. Marital Status	12. Was	Decedent	Ever in U.S	S. 13. V	Vas Deced	lent of Hi	spanic Ori	gin? (Sp	pecify Yes or No Rican, etc.)	0-			ican Indian,	
ours after death with the Marylan rel', or iteme 23e or 28e-f show Examiner must be notified at	Ē	1 Never Married 2xx Mar		ed Forces? Yes 2 □ ! is, Give			Yes :		Specify:	i, ruenc	nican, ecc.)			, White		
rel',	d b	3 Widowed 4 Divorced	Yea	r or Dates:				140	Spoony.				Specify:	wn	ite	
filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or iteme 23a or 28a-1 show ant, it a Medical Evantiner must be rediffied at	Completed	15. Deceder (Specify only highe	nt's Education est grade comple	eted)		16a. Deced	lent's Usua kind of wor	il Occupa rk done d	ation during mos I)	t of work	king	16b.	Kind of Bus	siness/l	ndustry	
within ane. than	du	Elementary/Secondary (0-12)	Colle	ege (1-4or (5+)	Ware						B	est I	700	d Baking	
Hygie Hygie ther ant,	ပိ	17. Father's Name (First, Middle,	Last)								e (First, Middl	1			Daking	
ld be ental ked o	To Be	Thomas Pedd	icord						В	ess	ie G	ord	on			
should be ind Mental in marked c	-	19a. Informant's Name/Relation:	ship <i>(Type, Prin</i>	t)		19b. Mailin	g Address	(Street a	and Numbe	er or Rui	ral Route Num	ber, City	y or Town, S	State, Z	p Code)	
and 2 ealth a n 27 Is		Josephine Pe	ddicor	d W	ife	3604	Kes	wic	k Ro	ad,	Balt:	imo	re, N	lar	yland 212	2 1
ss 1 a of He item		20a. Method of Disposition	a 🗆 🗆	Ot-1-	20b. PI	lace of Dispos	sition (Nan	ne of ther plac	e)		Date	20c.	Location - 0	City or	own, State	
Pages nent of ant: If it ury or o		1 👿 Burial 2 □ Cremation 1 □ Donation 5 □ Other (5		from State	Çe	dar Hi	11 Ce	mete	ery	4/11	/2005	G1	en Bu	rni	e, Marylan	d
permit Pages 1 and 2 should be filed within 72 hours Depar ment of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; any in ury or othar treumatic event, the Medical Exanone.		21. Signature of Funeral Service	Lice see			22 B	. Name an	d Addres	ss of Facilit	y itz	Funera	a1 H	ome.	Inc	21211	
202 g g		Mym 1). He	NSL	レ	-							Maryl.	and	, 21211	
		23a. Part1. Enter the disease, of shock, of heart failure. Lis	r complications t only one cause	that caused on each li	the death ne.	. Do not ente	er the mod	e of dyin	g, such as	cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death	
Physician		Immediate Cause (Final disease or condition resulting in death)	_ a L	Vig	Con	new									years	
/Medical Examiner		Todaliang in County	D	ue to (or as	a consequ	uence of):									•	
	ē	Sequentially list conditions, if any, leading to immediate	b	ue to (or as	a consequ	uence of):								-		_
uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S													
executed an and rial-transi	Exa	resulting in death) Last	C	ue to (or as	a consequ	uence of):					-	-				
death certificate be exattending physicland for use as the buria	cai		d													_
ing ph	Med	IF FEMALE:														
ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	1 🗀	s, outcome Live birth	2 Fetal	death 3	Ectopic pr						23d. Date Mon		very Day Year	
The faw requires that the death certificate be ate has been signed by the attending physicls bage 2 should be detached for use as the bu	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Pregnant a Unknown	t time of de	eath 5∟	Other (sp	ecity)								
w requires that the de been signed by the s should be detached	/ Ph	Part II. Other significant condit	ons contributin	g to death b	out not resu	ulting in the ur	nderlying c	ause give	en in Part I		23e. Did	tobacc	o use contri	bute to	the cause of death?	
puires n sign	d by										1 🖔	Yes	2 🗆 No	3 🗌 Pro	bably 4 Unknow	n
w red	iete										24a. We		24b. W	/ere au	opsy findings availabl	9
The law te has age 2	Completed											opsy formed 2	? d	rior to d eath? □ Yes	ompletion of cause of 2 No	
ilcian: Th certificate rector, pag	Be C	25. Was case referred to medic	al						26. Place	of Dea	th (Check only		,		20.10	_
nysic nis ce I direc	To E	examiner? 1 ☐ Yes 2 ☐ No	Hospital	1 🗌 Inpati	ent 2 🗆	ER/Outpatien	t 3 🗆 DC	Othe	er: 4□Nu	ursing H	ome 5 Re	sidence	Othe	r (Spec	whospice	
ing P		27. Manner of Feath Manner of Feath 5 ☐ Pend		Date of Inju (Month, Da	iry ly Year)	28b. Time of Injury		8c. Injun Worl			28d. Describe	how in	ijury occurre	ed	*	
Attending Physician: rr death. ector: Atter this certifica by the funeral director, t	cati	Accident invest	not be	Diana -4 la	ium. As ha		M		Yes 2□	No 1	28f Location	/Stroot	and Mumba	. o. O.	ral Route Number,	_
or Al after d Direct in by	Certification:	4 Homicide deter	mined 286.	building, e		ome, farm, str	eet, factory	, onice			City or T	own, St	ate)	ii Oi Au	ai noute Number,	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C		ng Physician: I Examiner: On		of examinat											
o the ithin 2 o the omple	Mec	29b. Signature and title of certifi		7 1112111101 51	aleu.		290	c. License	e number			29d. I	Date signed	(Month	, Day, Year)	
- 5 + ŏ		MARIA	ull	W			\mathcal{D}	3×	302	>		AF	MIL	8	2005	
N		30. Name and address of person	who complete	d cause of	death (Item	1 23a) (Type,	/ \				4 .					
1		stanon CHA	RURS	no	lele	O(N	Chr	ele	75	1200	ltmo	c	M) Z	120	4	
Sta Registr		31. Date filed (Month, Day, Yea.	2005	2. Hegist	rar's Signa	ture Ape	de)									

			State of Maryland	d / Depa		ealth ar		iene	12411
			Registrer 1. Decedent's Name (First, Middle, Last)		lineate of L	Jean	2. Date of Deat	ng. No."	3. Time of Death
	hysicia		DOROTHY E. PEAIS				04 · 08	Day Year	
	/Medic xamin		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or	Location of [4c. County of De	eth
			7 N. MONROE STREET		BALTIMO			NA	
	neral ector		5. Social Security Number 4 6. Sex 1 □ M 2 M F 7. Age (In yrs. Ia	is <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Day,	Year) 9. B	othplace (State or Foreign Country)
pue	22		Usual Residence of Decedent 10a. State 10b. County 10c. City,	, Town or Lo	cation				10d. Inside City Limits
Maryla	led a	tor		TIMOR					1 ✓ Yes 2 □ No
the r	TIN TI	irec	10e. Street and Number	MINOR	10f. Zip Code		10	g. Citizen of What C	Country?
th with	A TEL	Funeral Director	7 N. MONROE STREET		21223			USA	
er dea	MET.	uner	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Was Decedent of His f Yes, specify Cubar	spanic Origin n, Mexican, F	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Arr Black, Wh	
rs afte	Zam	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 1 1 No If Yes, Give 3 2 Widowed 4 □ Divorced Year or Dates:	1	1□Yes 2≝No	Specify:		Specify: 2	ACK
72 hot	ical E		15. Decedent's Education (Specify only highest grade completed)	16a. Decec	ient's Usual Occupa	tion		6b. Kind of Busines	
rithin 7	Mag	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	kind of work done d DO NOT use retired)	uring most of			haa
IL I I I I I I I I I I I I I I I I I I	nt, m		17. Father's Name (First, Middle, Last)	_('03	1001AN	18 Mother's	Name (First, Middle, N	ALTO, CHY	3CH00LS
should be filed with and Mental Hygiene.	nen z'r a narkau oner man haudan, yr nems zoa or ces- anov other traumatic event, the Mudical Examinat mast be mulified at	To Be	THOMAS JOHNSON			RUBY		alderi Sumamer	
2 shou	acmat acmat	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin			or Rural Route Number,	City or Town, State,	Zip Code)
1 and 2	her tra		LINDA PEALS		MONROE	ST.	BALTO. MI		3
Pages 1	or of		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	metery, cren	sition (Name of natory or other place			Oc. Location - City o	
Dallillore, permit. Pages 1 av Department of Hea	any injury or once.		'4 □ Donation 5 □ Other (Specify) ARB	unus	. Name and Address	of English		BALTO. ME)
Demit.	any is		Danck (VA	UGHN C. G	REENE	FUNERAL ;	ERVICE MO 2122	9
-	1		23a. Part1. Ent of the disease, or complications that caused the death, shock, or leart failure. List only one cause on each line.						Approximate Interval Between
Physi			Immediate Cause (Final disease or condition	1			Porcino		Onset and Death
/Med Exam	dical niner		resulting in death) Due to (or as a consequence)						
10.00		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):					
cuted	ransit	Examiner	that initiated events C.						
e be exe	the burial-transit		resulting in death) Last Due to (or as a conseque	ence of):					
icate t	s the t	edicai	d						
CA Centil	d for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant		le .			23d. Date of de	livery
e deat	detached for use	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
that th	detacl		Part II. Other significant conditions contributing to death but not result	ting in the ur	ideriving cause give	n in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
The could us, F.C. BOX 00/00, The law requires that the death certificate be executed that has been signed by the attending physician and	should be delt	ed by			, ,		1 ☐ Yes		robably 4 Unknown
aw re	i (V	ompieted					24a. Was an		utopsy findings available completion of cause of
	page	Соп					perform	ed? death?	
VILAI F lician: Th	rector	Be	25. Was case referred to medical examiner?		Other		Death (Check only one		
ding Phya	aral di	: To	27. Manner of Death 28a. Date of Injury 2	R/Outpatient 28b. Time of	28c. Injury Work	4 Nursir	ng Home Resider 28d. Describe hov		ecify)
ath.	e fune	atior	1 → Neural 5 → Pending (Month, Day Year) 2 → Accident investigation	Injury		? es 2□No		,	
or Atte	n by th	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)		et, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
pital c	filled		29a. Certifier 1 Sertifying Physician: To the best of my know	dadaa daash					<u></u>
To the Hospital or Attending Physician: within 24 hours after death.	completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Sectifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	on and/or inv	estigation, in my opi	e, date and p inion, death o	lace, and due to the cal occurred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
Tot	com	Σ	29b. Signature and title of certifier		29c. License		1	d. Date signed (Mon	th, Day, Year)
	0		//horn / Le duon	16		0793	30 1	tp1.1	2005,11
10			30. Name and address of person who completed cause of death (Item 2)	-				Barra	717~7
F	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatu		PAUL PL	nut :	suc 40+1	GATTO MD	2202
R	egistra	ar	APR 1 2 2005 Marie &	Spark	V				

			Please	State of Mary	land / De	partment of H	lealth and M	-	•	e.
			1 - State Registrar		C	ertificate of	Death	R	eg. No. U U	1 6416
	Physicia /Medic		1. Decedent's Name (First, Middle, La GLORIA R. PA	TIERSON_				2. Date of Dea Month	Day Y	ear 1.29AMM
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Death		4c. County of	. 1.
	Funevat		Singuitospital of 5. Social Security Number 6.5	Bathmere 7. Age (In	yrs. last birthd	av) If Under 1 Year	MUY C IT Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Funeral Director			□M 200F	. V.	Months Days	Hours Min.	(Month, Day	, Year)	Country) MD
	and and		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town o	r Location				10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural; or Items 23a or 28e-f show if It then 27 is marked other then "natural; or Items 25 is not 16e-f show or other traumatic event, the Medical Examinat must be notified at	tor	MO BALTIM	ORE G	WYNN	OAK				1 ☐ Yes 2 MiNo
	or 284	Funeral Director	10e. Street and Number	N		10f. Zip Code		1	log. Citizen of Wha	at Country?
S	eath w	eral	6800 LIBERTY R	DAD # 709 12. Was Decedent Ever	in U.S.	212	D7 Iispanic Origin? (Spe	cify Ves or No-	US/	American Indian,
200	after d	Fun	1 Never Married 2 Married	Armed Forces?	III 0.3.	13. Was Decedent of H		Rican, etc.)	Black, 1	White, etc.
na Lanaskr-pat Maryland 21215-0036	within 72 hours after dea ene. then "natural", or Items he Medical Examinal m	d by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1☐ Yes 2 <mark></mark> No	Specify:			BLACK
15-	in 72 h	Completed	15. Decedent's E (Specify only highest gra	ide completed)	(G	ecedent's Usual Occup live kind of work done of e. DO NOT use retired	durina most of workir	ng	16b. Kind of Busin	ess/Industry
Lanastr Iand 2121	giene. giene. er ther	mo	Elementary/Secondary (0·12)	College (1-4or 5+) 2 YRS	PAY	ROLL CL	ERK		STATE D	F MD
and and	be file	Be	17. Father's Name (First, Middle, Last,	/			18. Mother's Name		Maiden Sumame)	
L L	hould id Mer marke	2	ROLAND LANCAS 19a. Informant's Name/Relationship (19b M	ailing Address (Street		TITH LBoute Number	r City or Town Sta	ate Zin Code)
	permit. Pages 1 and 2 should be filed within Department of Headth and Mental Hygiene. Important: if Item 27 is marked other then any injury or other traumatic event. The Magnee.			SON	680	O LIBERTY	~ 5	109 B	ALTO. M	0. 21207
ी/ Baltimore,	of He		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □	1	Ob. Place of Di cemetery,	sposition (Name of crematory or other place		ate	20c. Location - Cit	
ii.	t. Partmer rtant rtant		 4 □ Donation 5 □ Other (Specification) 21. Signalure of Funeral Service Licer 	y) k	KING P	ARK	04.08	- 05 K	ANDAUS	
Bal	Depa Impo any i		21. Signature of Funetal Service Cicel	1590		22. Name and Addres VAUGHN C. (5151 BAUTO	GREENE	FUNERA	LO SERVI	1CE 21229
			23a. Part1. Enter the disease, or com shock, or heart fillure. List only	plications that caused the	death. Do not					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Colon Car	ncer					Onset and Death 2/2/EGGS
	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):					
		her	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lise as or injury	b. Due to (or as a cor	nsequence of);					
	or Attending Physicien: The law requires that the death certificate be executed bited death. Diffector: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cor	necquanae of):					- 52
760,	te be ex ysician ie burial	cal E		Due to (or as a cor	risequence or):					
687	tificate ig phys as the			_ d						
Box 68	death certificate a attending phy: d for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr	Fetal death	3 ☐Ectopic pregnancy	,		23d. Date o	,
0.	that the dec ed by the a detached (ysic	1 Yes 2 No 9 Unknown	4□Pregnant at time 9□Unknown	of death	5 Other (specify)			iviona.	Day Teal
ر. ح.	s that the	y Ph	Part II. Other significant conditions	ontributing to death but no	ot resulting in th	e underlying cause giv	en in Part I.	23e. Did tol	bacco use contribu	ite to the cause of death?
ords	w requires that been signed be should be det	ted t	Diffuse liver me	tastascs				1 🗆 Ye	es 2/2 No 3[□ Probably 4 □Unknown
3ec	ne law r has be ge 2 sh	Completed by	Sclensing Chola	ngitis				24a. Was a autops	y prio	re autopsy findings available or to completion of cause of
Tal.	icien: The l certificate ha		Heratic Enception 25. Was case referred to media.	Mopathy			00 Disease (D. 1)	1 Yes	2 No 1	Yes 2 No
Ž	Physicie this cert al directo	To Be	examiner?	Hospital: 1 Inpatient	2 ☐ ER/Outpa	tient 3 DOA Oth	26. Place of Death er: 4 ☐ Nursing Hon		ence 6 🗆 Other ((Specify)
Division of Vital Records, P.O.	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Tim Inju	ry Worl	k?	8d. Describe ho	ow injury occurred	
isio	Ntendi death. ctor: A y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not b		At home, farm		Yes 2 □No	8f. Location (St	reet and Number	or Rural Route Number,
Div	al or A	Certi	4 Homicide determined	building, etc. (Sp	pecify)	onout, tablery, only		City or Town	n, State)	.(
	To the Hospital or Attending Physicien: whin 24 hours after death To the Funerel Director: After this certific completely filled in by the funeral director,	ical ((Check only 2 Medical Exar	ysician: To the best of my niner: On the basis of exam	knowledge, d	eath occurred at the tin r investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the ca	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
	To the Pwithin 24 To the Foomplete	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licenso			9d. Date signed (A	
	A 3 = 3		1/200	1. W.	MD	75	1054911	1	4-4-2	005
	7		30. Name and address of person who	completed cause of death	(Nem 23a) (Ty	pe, Print)	A. A.	N 12 A	12,100.	EMD 21215
	-64	•	31. Date filed (Month, Day, Year)	2. Registrar's S	Signature	W. DEIVE	MENEN	E. DA	שושיותין	omp grap
	Sta Registr		APR\1 2 200	5 Blacker	1. So	suli)				

			for State Registrar	State of M	laryland / Depa <i>Cel</i>		of Health a of Death	ınd Ment	al Hygie	400	5	1241	13
	Physici	an	Decedent's Name (First, Middle MANY		D	LATNIC			ate of Death	Davi	rear	3. Time of De	eath M
	/Medic Examin		4a. Facility Name (If not institution				own, or Location of			4c. County of	Death	1:15 P	
	Examili	ier	FUTURE CARE (•	,	40. Ony, 10		TERSTO			LTIM	UDE	
-	Funeral		5. Social Security Number	+	ge (In yrs. last birthday)	II Under 1							oreian
	Director		217-92-3260	1□M 2X F	79 Yrs.	Months E	Days Hours	Min. 02	ate of Birth 100th Day 1727/19	25	Countr	UKRAIN	NF
	ס		Usual Residence of Decedent									51111121	
	nylan how		10a. State 10b. Count	1	10c. City, Town or Lo	cation					10	d. Inside City l	Limits
	e Ma	cto	MD	N/A	BALTIMOR	Ξ.						1 Yes 2	□No
	or 28	Director	10e. Street and Number			10f. Zip Co	ode		10g.	Citizen of Wh	at Countr	y?	
	23a	ai	6604 EBERLE DRI	VE APT. 203		2121	15			U.S.	Α.		
	ams erms	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Deceder	nt of Hispanic Orig	in? (Specify Y	(es or No-	14. Race	America White, e		
98	or It	J.	1 Never Married 2 Ma	rried 1 ☐ Yes 2 🛣	No	1□Yes 2	/		, ,	Specify:	WH		
21215-0036	within 72 hours after deeth with the Maryland ene. than "netural", or Itams 23a or 28a-f show than "hedical Exactif or most be notified at	d by	3 Nidowed 4 □ Divorce	Year or Dates						Орволу.			
5	net net	Completed	15. Decede (Specify only high	nt's Education est grade completed)	(Give	dent's Usual (kind of work (done during most	of working	16b	. Kind of Busi	iness/Indu	istry	
12	withir lene. than	Ę	Elementary/Secondary (0-12)	College (1-4or 5+	PURCI	DO NOT use : J N C F D	reurea)			F00D			
	Hygie ther ant,		17. Father's Name (First, Middle		FORCI	INSLI	18 Mother	r's Nama /Fire	t, Middle, Maid		1		
and	Mentai Mentai arked o atic eve	Be	MOSES	. 2001/	SDE	CTORMAN			t, MIGGIO, MAIL	Jen Sumame,		CVIN	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "netural", or Itams 23a or 28s-f sho other traumatic event, the Medical Esphirsormatics notified at	2	19a. Informant's Name/Relation	chin /Tuna Print)					t- M C			LEVIN	
Ma	d 2 sho th and 7 is ma trauma		SANDRA GURFOLI			_	Street and Number						7
	of Health item 27		20a. Method of Disposition	NO / SISIER	20b. Place of Dispo			Date		Location - C			
آور	Pages nent of int: If its iry or o		1 Burial 2 Cremation		cemetery, crei	natory or othe	er place)				•		
Baltimore,	rtant rtant		'4 □Donation 5 □ Other (BALTIMORE			4/10/20		ISTERS			
Bal	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service	Lions	22	Name and	Address of Facility	SOL LE	EVINSON	l & BRO	S.,	INC.	_
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	Physician /Medical Examiner		shock, or heart lailure. Lis Immediale Cause (Final diseaspor condition resulting in death)	a	illie.	/ •	vejvzá	All	maiory arrost,		G	nterval Between nset (Ind Dea	
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.O. Box	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregpent in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic preg Other (speci				23d. Date Month		/ Day Yea	ır
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of	Phys this ral di	- T	1 Yes 2 No 27. Manne of Death	1 ☐ Inpat			4 Nur		6 Residence				
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Division	I or Attendi after death. Director: A I in by the fu	itie	4 Homicide determination	prined 286. Place of Ir building, e	njury - At home, farm, str stc. <i>(Specify)</i>	eet, factory, o	тсе		ocation (Street lity or Town, St		or Hurai	Houte Number	r,
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	ithin the mple	Me	29b. Signature and title of certific	er and manner s	nutou.	29c. I	icense number		294	Date signed (Month D	ay, Yearl	
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-			/ /	, , , , ,	VV/		1/1/12	59		7/8	(0)		
2	ŧ		30. Name and address of person	who completed cause of	death (Item 23a) (Type,	Print)	Sun.	1	00 /	11	7,1	200	
	- 01	State 31. Date liled (Month, Day, Year) Registrar's Signature											
	Sta Registi		ADD 19	2005	A GOS	w							

			1 - For Stata Registrar	State of Marylan	-	artment of F		ınd Mer		giene Reg. No.	11115	124	11;
	Physicia	an	Decedent's Name (First, Middle, La: MARCIA	_		PIERSON			Date of Dea Month PRIL	ath Day	2005 Year	3. Time o	
	/Medic Examin		4a. Facility Name (If not institution, give	a street and number)		4b. City, Town, o	or Location of		RIL		County of Death	1:25	РМ
			4535 MARYKNOLL ROA			RANDALLS		D4 Hea			ALTIMORE		
	Funeral Director		5. Social Security Number 6. S 215–50–1201	ex 7. Age (In yrs.)	Yrs.	If Under 1 Year Months Days	Hours 1	Min. 02	Date of Birt (Month, Da 2/01/1	949	9. Birtt Coi	nplace (State ountry)	or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cih	, Town or Lo	cation		1				10d. Inside C	ity Limite
	Maryla	tor	MD BALTIMOR		NDALLS								2√ No
	or 286	Direc	10e. Street and Number			10f. Zip Code		_		_	zen of What Co	untry?	
	ns 23e	Funeral Director	4535 MARYKNOLL ROA	12. Was Decedent Ever in U	S. 13. V	21133	Hispanic Orio	zin? (Specify	Yes or No		.S.A.	ican Indian,	
õ	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or ltems 23e or 28e-f show event, the Mcdiral Examinar must be notified at		1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 \ No		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2【】No	an, Mexican Specify:	, Puerto Rica	an, etc.)		Black, White Specify: WH]	e, etc.	
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	s 1 and 2 if Health itam 27 i		JANE PIERSON / MO 20a. Method of Disposition			ROLAND A sition (Name of natory or other pla		BALT :			21211 ecation - City or	Town, State	
aitimor	90 = 5		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Inditional Itom State		natory or other pla DH CONG.		4/10/2	2005		DLAWN, M		
Sall Sall	permit. Page Department o Important: If eny injury or once.		21. Signature of Funeral Service Licer		22	. Name and Addre	ss of Facility	У	, ,	S01	L LEVINS	SON & E	
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	Physician ¹		shook, or hear failure. List only Immediate Cause (Final disease or condition	one cause on each line.	MOTE				opa.o.y a.			Interval Be Onset and	tween
	/Medical Examiner		resulting in death)	Due to (or as a consequence	uence of):							- 1 g	CVS
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00/	certificate nding phys	edical	•	d									
ZOZ	death certifica attending ph d for use as th	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnanc	у				23d. Date of deli		Year
5	the death y the atter iched for u	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eath 5	Other (specify) _					Wichti	Day	7041
λ, T	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions of	contributing to death but not resi	ulting in the u	nderlying cause gr	ven in Part I.		23e. Did to	obacco u	use contribute to	the cause of	death?
ecoras	require een sig	eted	Insony	21					1 🗆 1	Yes 2	□No 3□Pro	obably 4 🕡	Unknown
Z Z	The law ale has b page 2 sl	Comple	V						24a. Was autop perfo		24b. Were au prior to death?	topsy findings ompletion of c	available cause of
Vital	sician: The lav certificate has rector, page 2	စ	25. Was case referred to medical				26. Place	of Death (C	1 ☐ Yes		1 Tes	2□ No	
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00	iding Phys th. : After this funeral di	tlon:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ryat rk?]Yes 2∐N		. Describe h	now injur	y occurred		
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5	pital o	Cer	29a. Certifier 1D Certifying Ph										
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina and manner stated.	tion and/or in	n occurred at the ti vestigation, in my o	me, date and opinion, deat	d place, and th occurred a	at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
	To th withir To th comp	W	29b. Signatule and little of certifier			29c. Licens				29d. Dat	te signed (Month	, Day, Year)	
0	×		John John John John John John John John	Who no	22a\ (T	D56	2011			41	8/05		
Q	6		30. Name and address of person who	completed cause of death (Item	23a) (1ype,	Han	over	54	Bal	Linu	ve, mo	212	25
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	8 0					1		
	Registr	ar	APR 1 2 2005	Blother St	J. 5 J. 3 C.	4					· · · · · ·		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 5

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 20<u>05</u> April **Physician** Year 11, WEIR 3:40P ELLA OUEEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lutherville Baltimore College Manor 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) August 18, 1912 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M 2 92 Yrs. Missouri 212-40-0642 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f Health and Mental Hygiene. item 27 Is marked other than "naturel", or Items 23e or 28e-f show other traumatic event, I've Medical Evariner must be notified at 1 Tes XXNo Directo Maryland Baltimore Lutherville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 300 West Seminary Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene.
Importent: If item 27 is marked other than "naturel", or lier any injury or other traumatic event, the Medical Examina 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White þ XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical 5+Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Elizabeth Getz Morris John Weir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Q Peterson Dt.r 142 Brandon Road Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State GreenMount Crematory | 4/14/05 Baltimore, Maryland □Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 21 Signature of Funeral Service Licensee mnis & sken 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DIVERO week disease or condition resulting in death) -05 /Medical Due to (or as a consequence of): **Examiner** veeks atera Sequentially list conditions, if any, is adding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Heart tailure 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed histor 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed 1 Yes 2 DNO To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 2 ER/Outpatient 3 DOA this hours after death.

Inerel Director: After this y filled in by the funeral di 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 / Homicide within 24 hours a To the Funerel (1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balton 6301 N.CL D Mc Connell William 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Steven J. Rackey 05-2417 DOS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

+ 1	,		1 - For State Registrar	State of Maryl		epartment of He Certificate of D			giene 005	12416
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	ow at		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town o	or Location				10d. Inside City Limits
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Baltimore,	Pages 1		20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			isposition (Name of crematory or other place) aven Mem. Pk		2005	20c. Location - City or Glen Burnie	Town, State e, Maryland
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y	nd transi	Examiner	that initiated events	c						
Š.	be executed sician and burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):					
2 2 2 2	the the	dicai		_ d.						1
S X	certificanding plans as t	hysician/Med	IF FEMALE:	23c. If yes, outcome of pregnance	cv				024 Data et d	-1
ROX	death e atten	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	leath 3 [Ectopic pregnancy Other (specify)			23d. Date of d Month	Day Year
j.	the d ay the	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown						
ς, Γ	w requires that the death certific been signed by the attending p should be detached for use as	by Pi	Part II. Other significant conditions	ontributing to death but not result	ing in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
2	equire en sig ould b							1 🗌 Yes	s 2 2 N o 3 □ F	Probably 4 Unknown
o e c o	law reas be	Completed						24a. Was an		autopsy findings available completion of cause of
ב	The ate h page	mo:						perform	ed? death?	
VII	Physician: The this certificate ral director, page	Be C	25. Was case referred to medical examiner?				26. Place of Dea	ith (Check only one		
-	d is	မ	1 ☐ Yes 2 ☐ No		R/Outpatien		4 L Nursing F		nce 6 Other (Sp	ecify)
	ling F After unera	lon:	27. Man of Death 1 Natural 5 ☐ Pending	(Month, Day Year)	8b. Time of Injury	28c. Injury Work		28d. Describe how	w injury occurred	
<u>s</u>	ttend death stor:	icat	2 Accident investigatio 3 Suicide 6 Could not b	e See Blace of Injury At hom	o form of		Yes 2 □ No	29f Location (Str.	ont and Number or I	Pural Bouta Alumbas
UNISION	or A after Direct in by	ertification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, iarm, siri	евт, тастогу, оптсе		City or Town,	eet and Number or F State)	nurai Houte Number,
	spite	O	29a. Certifier 1 Certifying Pt	nysician: To the best of my knowle	edge, death	occurred at the tim	e, date and place	and due to the car	use(s) and manner a	as stated.
	To the Hospital or Attending Ph within 24 hours alter death. To the Funerel Director: Alter to completely filled in by the funeral	edical	(Check only 2 Medical Example)	niner: On the basis of examinatio and manner stated.	n and/or inv	estigation, in my op	pinion, death occu	rred at the time, da	te and place, and du	e to the cause(s)
	To ti withii To ti comp	M	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mor	nth, Day, Year)
	11		1 XX	Hota		KE	5000	000 /	Tpric .	7. 200 F
	10	1	30. Name and address of person who	competed cause of de ## (#em 2	23a) (Type,	Print)	_		0	3 Alto HO
				el HAno	we	LL, 700	OF	ANKLIN) guarce	7, 2005 Dr 21237
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2	32. Registrar's Signatur	* A	books				
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Calibraist Center for Hospice Care Towson Society Security Number Society Security Number Society Security Number Society Security Number Society Security Number Society Security Number Society Security Number Society Security Number Society Security Number Society Security Number Society Security Number Society Security Number Society Security Number Society Security Number Society Security Number Society Security Number Society Security Number Society Security Number Security Number Security Number Security Security Number Security Security Number Security Security Number Security Security Number Security Number Security Security Number S	eath Day Year 3. Time of Death 6:18 AM M
Director 200-14	Baltimore
The property of the property o	Day, Year) Country)
The property of the property o	10d. Inside City Limits 1 □ Yes 2 X No
The property of the property o	USA 14. Race - American Indian, Black, White, etc. Specify:
Marianne von Rigler/Wife 820 Stags Head Road Towson, Md. 212 200. Place of Disposition (Name of Longitude) Date 200. Location - City or To approach of the Committee of Place of Disposition (Name of Longitude) Apr 12 Baltimore, Mi 21. Signature of Fundation 3 (Planoval from State of Place) The Stage of Disposition (Name of Longitude) Apr 12 Baltimore, Mi 21. Signature of Fundation Servicy Ucensee NOSSU Physician (Marianne Von Rigler/Wife 820 Stags Head Road Towson, Md. 212 Baltimore, Mi 22. Signature of Fundation Servicy Ucensee NOSSU Physician (Marianne Von Rigler/Wife 820 Stags Head Road Towson, Md. 212 Baltimore, Mi 22. Signature of Fundation Servicy Ucensee NOSSU Physician (Marianne Von Rigler/Wife 820 Stags Head Road Towson, Md. 212 Baltimore, Mi 23. Signature of Fundation Servicy Ucensee NOSSU Physician (Marianne Von Rigler/Wife 820) Signature of Fundation Servicy Ucensee NOSSU Physician (Marianne Von Rigler/Wife 820) Signature of Fundation Servicy Ucensee NOSSU Physician (Marianne Von Rigler/Wife 820) Signature of Fundation Servicy Ucensee NOSSU Physician (Marianne Von Rigler/Wife 820) Signature of Fundation Servicy Ucensee NOSSU Physician (Marianne Von Rigler/Wife 820) Physician (Marianne Von Rigler/Wife 820) Signature of Fundation Servicy Ucensee NOSSU Physician (Marianne Von Rigler/Wife 820) Physician (Marianne Von Rigler/Wife 820) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of	16b. Kind of Business/Industry
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Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Baltimore, Maryland 21286 arrest, Approximate
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25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death North, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 27. Manner of Death North North, Day Year) 28b. Time of Injury Work? 28c. Injury at Work? 28d. Describe how injury occurred to medical examiner. To the best of my knowledge, death occurred at the time, date and place, and due to and manner stated. 28c. License number 28d. Describe how injury occurred to medical examiner. To the best of my knowledge, death occurred at the time, date and place, and due to and manner stated.	
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The state of the s	opsy prior to completion of cause of death?
zsa. Centile. Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Inc.) 29	sidence 6 Other (Specify)
zera. Centifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as structured at the time, date and place, and due to the cause(s) and manner as structured at the time, date and place, and due to and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, A	(Street and Number or Rural Route Number, own, State)
29d. Date signed (Month). 29d. Date signed (Month). April 10 30. Name and address of person who completed cause at the (Item 23a) (Type, Print)	, date and place, and due to the cause(s)
30. Name and address of person who completed cause a math (term 23a) (type, Print)	1
State 31. Date filed (Month, Day, Year) DD 19 32 Bagistrar's Ignature	Pratto and ZIZOX

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		1 - For State Registrar		yland / De	epartment of his Certificate of	Health and N	Mental Hyg	•	12419
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) KOJAL Reg 4a Facility Name (If not institution, give s	INALd		1NSON 4b. 971y, Town, o	or Location of Death	2. Date of Dea Month	Day Year 7 200.5 4c. County of Deat	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Dec. 18		hplace (State or Foreign untry) ginia
the Maryland r 28e-f show notified at	Director	10a. State 10b. County Maryland Howard 10e. Street and Number	1	0c. City, Town C	olumbia 10f. Zip Code			10g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 No
be filed within 72 hours after death with the Maryland tal Hygiene. Id Hygiene. Id other then "natural", or Items 23a or 28e-f show event, it a Modical Exerticer must be notified at	by Funeral Di	10492 Faulkner R 11. Marital Status 1 □ Nøver Married 2☑ Married 3 □ Widowed 4 □ Divorced	idge Circl 12. Was Decedent Ev. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	er in U.S.	210 13. Was Decedent of I If Yes, specify Cub 1 Yes 2 XNo	Hispanic Origin? (Sp ean, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	Specify:	e, etc.
Z I Z I D-UUJO d within 72 hours af giene " giene "natural", or tre M. die I Ereni	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cation	(7	decedent's Usual Occup Give kind of work done ife. DO NOT use retire Offset P	during most of world)	king	16b. Kind of Business/ State of M	
Maryland & d 2 should be filed th and Mental Hygin 7 is marked other traumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Wellington Robins 19a. Informant's Name/Relationship (Ty)		196. 1	Mailing Address <i>(Stree</i>)	Ada Th	ornton	Maiden Surname) or, City or Town, State, 2	
es 1 an of Heal of Heal fitem 2		Barbara Robinson 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		104 20b. Place of D cemetery,	92 Faulkne Disposition (Name of crematory or other pla ash Cremat	r Ridge C	Circle (Columbia, M 20c. Location - City or	D 21044 Town, State
baltimo permit. Page Department o Important: If any injury or		21. Signature of Emeral Service License	M012	90	22. Name and Addre Witzke Fu 5555 Twin	ess of Facility neral Hom Knolls R	les Inc	Lumbia, MD	
Physician /Medical Examiner		23a. Part1. Enter e disease, or complishock, or hard failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line. Due to ras a c	renal	syndi		or respiratory an	rest,	Approximate Interval Batween Onset and Death
bb / bu, ficate be executed physician and is the burial-transit	cal Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to or as a d	Consequence of	Bacte	no 7	Peritor	ritis	
ath certi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	☐ Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	y		23d. Date of del Month	ivery Day Year
wrequires that the debeen signed by the a	þ	Part II. Other significant conditions con	ntributing to death but	not resulting in t	he underlying cause gr	ven in Part I.	23e. Did to	obacco use contribute to ′es 2 /2 No 3 ☐ Pr	the cause of death?
	Completed						1 Yes	sy prior to death? 2 No 1 Yes	itopsy findings available completion of cause of
JII OI Jing Phy After this funeral d	ation: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 28a. Date of Injury (Month, Day)	28b. Tir	me of 28c. Injury	h <i>e</i> r: 4 ☐ Nursing H		ne) dence 6 □Other (Spe now injury occurred	cify)
LIVISION Attentitis after death rai Director: led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farn (Specify)	n, street, factory, office		28f. Location (S City or Tow	Street and Number or Ru vn, State)	ıral Route Number,
UIVI To the Hospital or At within 24 hours after d to the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Examile one)	sician: To the best of ner: On the basis of e and manner state	xamination and/	or investigation, in my	opinion, death occu	rred at the time, o	cause(s) and manner as date and place, and due	to the cause(s)
		29b. Signature and title of certifier	MD) Ab ((A = 22) =	29c. Licen	V144		29d. Date signed (Mont 4/7/09 ALTIMURA	
\	tate	30. Name and ddress of person who co	32. Registrar	s Signature	ype, Print) GROOM	NeStr	est B	altimore,	mp 21201

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 1 5 1 - For Stete Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day APRIL Year **Physician** REESE 9, 2005 10:00P. M WARREN CALVIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** BALTIMORE N/A KESWICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours XX M 2□F 80 219-12-8536 Yrs. MARYLAND Director 11-22-1924 Usual Residence of Decedent the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Mudical Examiner must be nutilised at 1 Yes 2/0/No **ELLICOTT** CITY MD. HOWARD Funeral Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number with BRIGHTLIGHT PL ACE 21043 U. S. A. 7943 death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status i filed within 72 hours after de l'Hygiene. other then "natural", or Items □Yes XXNo Yes, Give 1 ☐ Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE þ If Yes, Give Year or Dates: WW II 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) STATE MARYLAND permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other the any injury or other treumatic event. If IteM 2006. **ESTATE** DIRECTOR 0F REAL YEARS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ε. REESE LILLIAN HILDEBRANDT WARREN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7943 BRIGHTLIGHT PLACE, ELLICOTT CITY, MD.,21043 CYNTHIA J. REESE (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 04-14-2005 TIMONIUM, MARYLAND DULANEY VALLEY M.G. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TAGE ALZHEIMER'S Physician heentles disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes XX No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4XXNursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes XX No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1XXXVatural 2 \(\text{\text{Accident}}\) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. M after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 24 ho To the Fun completely f (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature at rle of certifie 0 2334 NUD APRIL 11, 2005 Of Spreet Baltime 21211 completed cause of death (Item 23a) (Type, Print) 2. Registrar's Sig 31. Date filed (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Richards Year Marshall 3:30P M April 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Renisance Garden @ Rider Wood Vil. Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 24. 1919 9. Birthplace (State or Foreign Country) UNLO **Funeral M**☐ M 2☐ F Director 86 310-12-8499 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is markad othar than "natural", or Itams 23a or 28a-f show traumatic evant, the Middical Examinat mast be notified at Director 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefield Road 20904 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: δ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mantal Hygier 7 is markad othar th 12 Chief Hydroligist Nat'l Weather Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ivan Russell Richards Margaret Jane Duffield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar trat once. Dave Richards / Son 11030 Gaither Farm Road, Ellicott City, MD 21042 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4/6/2005 ^¹ 4 □ Donation 5 □ Other (Specify) Balt/Wash Crematory Laurel. Maryland nature of Funeral Service Licenses 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 Part 1. Ententhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final **Physician** Coronary disease or condition /Medical resulting in death) reimers disease Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts. Examine attanding physician and for use as the burial-transit or Attanding Physician: Tha law requires that the death certificata ba exacutad that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ned by the Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, sign. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy 1 ☐ Yes 2 (No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Medical Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 3 DOA Aftar thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Aatural 5 Pending investigation death. 1 □ Yes 2 □ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To tha Funaral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Pulhumana, UD D 59524 April 5,2005 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOVEEN J. PUTHUMANA 3110 GRACEFIELD ROAD, SILVER SPRING MD20904 32. Segistrar's Signature 31. Date filed (Month, Day, Year) APR 1 2 2005 State and the Registrar

			1 - State of Mary		artment of Health and Martificate of Death	Mental Hygie Reg.	FOOD 1 CACC
	Physici /Medic		Decedent's Name (First, Middle, Last) MARY E. ROSA			2. Date of Death Month April 10.	Day Year 2005 3. Time of Death 8:00 A.M
	Examir	er	4a. Facility Name (If not institution, give street and number) CHESAPEAKE HOUSE 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	4b. City, Town, or Location of Death LINTHICUM If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death ANNE ARUNDEL
	Funeral Director		133-28-6366 1		Months Days Hours Min.	(Month, Day, Ye) 2/11/1935	9. Birthplace (State or Foreign Country) PUERTO RICO
	ie Maryłan Be-f show zijijed al	ctor	MD PRINCE GEORGE	BERWYN			10d. Inside City Limits 1 ☐ Yes 2X No
	with th	Dire	10e. Street and Number 8607 57TH AVENUE		10f. Zip Code 2 0 7 4 0		Citizen of What Country?
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other treumetic event, the Markeal Examinar must be notified at or other treumetic event, the Markeal Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				USA 14. Race - American Indian, Black, White, etc. Specify: WHITE
Maryland 21215-0036	vithin 72 ho ne. han "naturi e Medical E	mpleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king	. Kind of Business/Industry
р 9	filed v Hygie other t	e Co	12 17. Father's Name (First, Middle, Last)	НОМ:	EMAKER 18. Mother's Nam	e (First, Middle, Maid	OWN HOME den Sumame)
ylan	should be and Mental marked o	To Be	SATURNILO LOPEZ		NATAL	IA LOPEZ	
	and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print) MARIA ROSA / DAUGHTER	8607		RWYN HEIGH	TS, MARYLAND 20740
altimore,	Par Ind		1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	BALT/WAS	H CREMATORY 4/1	5/2005	LAUREL, MARYLAND
Ba	permit. Departr Importe any inju		21. Signature of Funeral Service Licensee	269	7601 SANDY SPRING	ROAD, LAU	RAL HOME, INC. REL, MARYLAND 20707
	Physician		23a. Part1. Enter the disease, or complications that caused the speck, or hearhfailure. List only one cause on each line. Immediate Cause (Final disease or condition a METASTATI)			or respiratory arrest,	Approximate Interval Between Onset and Death 4-1/2 YEARS
	/Medical Examiner		resulting in death) Due to (or as a con	nsequ <i>e</i> nce of):			
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Oue to (of as a condition of the c				
O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnanl in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of properties of the pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but no RAYNARD'S DISEASE	t resulting in the u	ndertying cause given in Part I.		to use contribute to the cause of death?
Vital Record	The law ate has b page 2 s	Completed				24a. Was an autopsy performed'	
	ding Physician: Th h. After this certificate funeral director, pag	tion: To Be	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Yes	2 ER/Outpatien 28b. Time of Injury	t 3 DOA Other: 4 Nursing Ho	h (Check only one) ome 5 ☐ Residence 28d. Describe how in	6 ★ Other (Specify, HOSPICE
Division of	ol or Attendi after death. I Director: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - building, etc. (S)	At home, farm, str. oecify)		28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edicai	29a. Certifier (Check only one) 1☐ Certifying Physician: To the best of my 2☐ Medical Exeminer: On the basis of examiner stated.	knowledge, death	n occurred at the lime, date and place, restigation, in my opinion, death occur	and due to the cause red at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complete	2	29b. Signature and title of certifier	hat	29c. License number		Date signed (Month, Day, Year)
	Ń		30. Name and address of person who completed cause of death	(Item 23a) (Type,	DC10200	AP	RIL 11. 2005
			Dennis Priebat. M.D. 110 31. Date filed (Month, Day, Year) 32. Sgistrar's S	Irving S	treet. NW. Washing	ston. DC 2	0010
	Sta Registr		APR 1 2 2005	ignature	ned		

			1 - For State Registrar		Marylan		artment of F	Health and N Death		ene 0 0 5	12423
	Physici	an	Decedent's Name (First, Midd	. ,	M. Roga	al olei			2. Date of Death Month	Day Yea	3. Time of Death
	/Medio		4a. Facility Name (If not institution			115K1	4b. City. Town. o	or Location of Death	April	9 2005 4c. County of Di	3:10 P. M
	Lxamii	iei	Washington Ad					a Park		Montgo	
	Funeral		5. Social Security Number	6. Sex 7	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 15,		Birthplace (State or Foreign Country)
	Director		213 05 7029 Usual Residence of Decedent	TUM ZUNF	84	Yrs.			Aug. 15,	1920	Maryland
	yland now		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Mar Sa-f sl	ctor	Maryland N/	A	В	altimo	re				1 X Yes 2 ☐ No
	with th	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What	Country?
	eath is 23s	eral	606 Jeffrey		dent Ever in U.S	S 112 1		225	positu Voc or No	U.S.	merican Indian,
9	after d	Fun	1 ☐ Never Married 2 ☐ Mar	ried Armed Ford	ces? 2 📉 No		_	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, W	
003	filed within 72 hours after death with the Maryland Hygiene. other than "naturel", or Itams 23a or 28a-f show ent, the Medical Evanture The Indified at	Completed by Funeral	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dat	tes:		1 ☐ Yes 2 🙀 No	Specify:		Specify: W	hite
<u>1</u>	n 72 h "nate	lete	(Specify only highe	t's Education st grade completed)		16a. Deced	ient's Usual Occup kind of work done	eation during most of work d)	ing 10	6b. Kind of Busines	ss/Industry
212	d withing the man	ошь	Elementary/Secondary (0-12)	College (1-	4or 5+)			rol Inspe	1	& M Hoi	serv
B	al Hyg	Be C	17. Father's Name (First, Middle,	,					e (First, Middle, Ma	aiden Sumame)	
<u> </u>	Ment Ment Marka Marka	2		lrew Golemb	oski				lia Umbos		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Itams 23a or 28a-f show early injury or other traumatic event, the Medical Evant net must be notified at once.		19a. Informant's Name/Relations Geraldine Gran		hter		g Address <i>(Street</i> Ward Stre	and Number or Run	a <i>l Route Number, (</i> rel, Mary		
Baltimore,	s 1 and the all item 2		20a. Method of Disposition		20b. Pf		sition (Name of natory or other place			c. Location - City	
Ē	Page nent o ant: If ury or		1 🔀 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S						/2005 B	altimore.	, Maryland
Salt	ermit. Pepartr nporta ny inju	14 □ Donation 5 □ Other (Specify) Holy Cross Cemetery 4/14/2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce							once Fune	ral Servi	ice, P.A.
	40 = 0 a		4001 Ritchie Highway Baltimore, Maryland 212								
	W-17		shock, or heart failure. List Immediate Cause (Final	only one cause on eac	ch line.	Hear	t Failure	ig, such as cardiac (or respiratory arres	t,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	r as a consequ		t Turrure				
	Examiner		Sequentially list conditions	b							
7	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a consequ	ence of):					
_	and al-trar	Examine	that initiated events resulting in death) Last	c	r as a conseque	ence of):					
8/60	death certificate be executed e attending physician and id for use as the burial-transit	cal		d							
0	entifica ing ph e as th	Med	IF FEMALE:			-					
X Q Q	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?		ome of pregnan th 2 Fetal on t at time of dea	death 3□	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
j.	that the death certific ed by the attending p detached for use as	Physician/Me	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9 Unknow		au1 5_	Other (specify)				,
S,	S L 00	by P	Part II. Other significant condition	ons contributing to dea	th but not resul	lting in the un	derlying cause give	en in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
cord	w require been sign should b								1 🗆 Yes	2 X No 3∏ F	Probably 4 Unknown
d)	e la has je 2	ompleted							24a. Was an autopsy	prior to	autopsy findings available completion of cause of
	icien: The la certificate ha	Co	25. Was case referred to medical						performe 1 ☐ Yes 2		
=	Physicien: this certific ral director,	0 8	examiner?	Hospital: 1 Inp	natient 2√7 E	R/Outpatient	3□ DOA Othe		me 5 Residence	e 6 DOthor (So	anife)
0	ng Phys fter this neral di	T:uc	27. Manner of Death 1 XNatural 5 ☐ Pendin	28a. Date of		28b. Time of Injury	28c. Injury Work		28d. Describe how		ecny)
DIVISION	ttendi death. tor: A the fu	catl	2 Accident investig	ation			M 1 []	Yes 2 □ No			
<u> </u>	el or Attending F s after death. I Director: After d in by the funera	Certification:	4 Homicide determ	ined 286. Place of	f Injury - At hon p, etc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or F State)	Rural Route Number,
	spite hours merel y filled		29a. Certifier 1 🔀 Certifyin	g Physicien: To the b	est of my know	ledge, death	occurred at the tim	ne, date and place, a	and due to the caus	se(s) and manner a	as stated.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	one)	and manne	is of examination	on and/or inv	estigation, in my or	pinion, death occurre	ed at the time, date	and place, and du	e to the cause(s)
ı	Vitt To To	Σ	29b. Signature and title of certifie	man			29c. License		29d.	Date signed (Mor	nth, Day, Year)
		-	30. Name and address of person	who completed cause	of death (Item 1	23a) /Tuno - F		083	4	4/11/05	•
	19		Dr. Irving Wes		300 Pic		*	Rockville	, Marylan	d 230850	
	Stat		31. Date filed (Month, Day, Year)	. 597	strar's Signatu	ire	P. W.		<i>H</i> .		
	Registra		APR 1	Z ZUUD Z	Meser 1	0° 6	SALL!				

			T = For State Registrar	State of Maryla		artment of He			ene2005	12424
Н		3	1. Decedent's Name (First, Middle, Last,)				2. Date of Death Month		3. Time of Death
4	Physici /Medio		Charles	Reed				April	B 2005	5 7:35 PM
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or L	ocation of Death	ì	4c. County of Dear	
			Northwest	Hospita	1	Randall			Baltin	
c	Funeral Director		5. Social Security Number 6. Se 236-44-2513 19 Usual Residence of Decedent	4	s. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	year) 9. Bin	thplace (State or Foreign buntry) VA
	land wo		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary f sh	ō	MD BALTIN	TORE W	INDSO	R MILL				1 ☐ Yes 2 🕅 No
	the 728a	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	death with the Maryland ims 23s or 28s-f show finust be notified at	Q E	1736 WINDING	BROOK V	VAY	2124	14		US	A
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp	ecify Yes or No-	14. Race - Ame Black, Whit	
ထွ	after or tte	Fu	1 Never Married 2 Married	1 ☐ Yes 2 KNo			Specify:	Trioditi, oto.j	Specify: 121	
8	72 hours after natural', or Ite dical Examina	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					. 0	LACK
21215-0036	natu	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupat kind of work done du DO NOT use retired)			6b. Kind of Business	/Industry
12	within and the state of the sta	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	SUE	T METAL	MIORKE	CO I	BALL ME	TAL CO.
7	filed within Hygiene. other than	ပိ	17. Father's Name (First, Middle, Last)	NIA	OTLL			e (First, Middle, M		-11.0 00
Maryland	Mental Mental arked o	o Be	CHARLES REED			1	ELEN	PENIDE	FITDAL	
2	should nd Men marke umatic	2	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Street an		al Route Number,	City or Town, State,	Zip Code)
Z	and 2 saith ai n 27 is iar trau		VINMOR REED		1736	MINDIN	JG BRI	DOK WA	AY . BALTO	mp 21244
re,	s 1 and if Health item 27 other tr		20a. Method of Disposition		. Place of Dispo	osition (Name of matory or other place)			0c. Location - City or	
Ë	Pages nent of nnt: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)		LOODLA		04-1	5.05 F	SALTO A	AD OIL
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event. If a Medical Examinating the notified at ODGs.		21. Signal re of Funeral Service Licens			2. Name and Address	of Facility	FINIFON		
0	88 5 8		Vanga (1	5	51 BALTO.	NATT PI	KE BALI	ro. Mio.	21229
*			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the de ne cause on each line.	eath. Do not ent	ter the mode of dying,	, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Athero	sclev	otic. Ca	rdiovasa	war Di	Sease	Onset and Death
п	/Medical Examiner		resulting in death)	Due to (or as a cons						
в	Examine,		Sequentially list conditions,	b. Hyper Due to (or as a cons		5100		-		yeares.
-	bed isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 (0 (01-23 a cons	equence or).					
	xecul and	Examiner	that initiated events resulting in death) Last	c Due to (or as a cons	equence of):					
8760,	death certificate be executed e attending physician and of for use as the burial-transit	calE		đ						
9	ificate g phy as the	edlo		V						
Вох	eath certific attending pl	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		∃Ectopic pregnancy			23d. Date of de	livery
m.	death e atte	icla	in the past 12 months?	1 Live birth 2 ☐ For a line of a li		Other (specify)			Month	Day Year
P.O.	that the de ed by the detached	Physician/Med	9 🗆 Unknown	9LI Unknown						
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but not i	resulting in the u	inderlying cause giver	n in Part I.			the cause of death?
ecords,	w requir been si should l							1 □ Yes	s 2⊠No 3∏P	robably 4 Unknown
ပ္ပ	ne law r has be ge 2 sh	ple						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u> </u>	ate pa	Completed						perform 1 ☐ Yes 2		2 □ No
of Vital	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:	,			th (Check only one)	0.000
of \	this at dir	6	I Tes 2000	1 🗀 Inpatient 2	28b. Time o		4 🗀 ivuising no	ome 5 Resider	nce 6 Other (Spe	cify)
n C		lon	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year,) Injury	Work?	es 2 No	Zou. Describe not	w injury occurred	
Sic	l or Attending after death. Director: After I in by the lune	Ical	3 Suicide 6 Could not be	28e. Place of Injury - A	t home, farm, st			28f. Location (Str.	eet and Number or R	ural Route Number.
Division	= e = c	Certification:	4 Homicide determined	building, etc. (Spe	ecify)	,,		City or Town,	State)	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	aC	29a. Certifier 1 Certifying Phy	rsician: To the best of my l	nowledge, deat	th occurred at the time	e, date and place,	and due to the car	use(s) and manner a	s stated.
	te Ho	edical	(Check only 2 Medical Examone)	iner: On the basis of exam and manner stated.	nation and/or in	vestigation, in my opi	inion, death occur	red at the time, da	te and place, and due	e to the cause(s)
	To the Comp	ž	29b. Signature and title of certifier	10-10-10-	_	29c. License		29	d. Date signed (Mont	th, Day, Year)
)	de		Journafor	Grove De		,	Presid	+	focil 8,	3(CC)
	io		30. Name and address of person who o	ompleted cause of death (I	tem 23a) (Type,	Print)	2 1 0 0 0 1	24 2 1	ال د سرماداله	2511C CIL
	W		Jenniferz Yarke	, alo Noutha	sent Hosp	x tal 5401 0	12002 PM	Ka Kand	CHISTOURY	70 41100
	Sta Regist	ate rar	30. Name and address of person who control of the second o	005 States	J. S.	never				

			1 - For State Registrar	State of Maryl	and / Depa <i>Cei</i>	artment of h rtificate of	lealth and i Death		ienje () () 5 ng. No.	12425
	Phýsici		Decedent's Name (First, Middle, Last, HELEN	C RUI	VGE			2. Date of Deat Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	same		or Location of Deat	h	4c. County of De	eth
	Funeral Director			7. Age (In)	yrs. last birthday) Yrs.		If Under 24 Hrs Hours Min.	8. Date of Birth	9. Bi	rthplece (State or Foreign PA
	Maryland a-f ehow	ctor	Usuel Residence of Decedent 10a. State 10b. County N.Y. QUEENS		City, Town or Lo					10d. Inside City Limits 1X Yes 2 ☐ No
	with the	Director	10e. Street and Number 189-02 64th AVENU	JE APT. 5-G		10f. Zip Code 11365	,	1	0g. Citizen of What C	Country?
036	n 72 hours after death with the Maryland "natural", or iteme 23a or 28a-f ehow solical Examinational be notified at	by Funeral		12. Was Decedent Ever i Armed Forcee? 1 Yes 2 No If Yes, Give Year or Dates:				Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
9500-61212	within 72 ane. than "nai	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	DO NOT use retire	during most of wo.	rking	16b. Kind of Busines:	
<u>D</u>	be filed htal Hygie od othar event, I	Be	17. Father's Name (First, Middle, Last)	<u>.</u>	VEINSTEII		18. Mother's Na	me (First, Middle, M		BERKOWITZ
Maryi	should and Mer is mark sumatic	To	SAMUEL 19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ural Route Number,	City or Town, State,	
ore, M	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other treumatic ex once.		MILTON ROSENZWEIG, 20a. Method of Disposition 1 \(\Delta \) Burial 2 \(\text{Cremation} \) 3\(\text{CP} \)	20 semoval from State	b. Place of Dispo	sition (Name of natory or other pla	ce)	18	PA 18509 20c. Location - City o ALTON, PA.	
Baitimore,	permit. Pa Departmer Important any injury 2000.		21. Signat r of Funeral Service Licens		22	. Name and Addre	ess of Facility	OL LEVINS	SON & BROS	
ľ	Physician		23a. Part1/Enter the disease, or compleshook, or heart talluje. List only of Immediate Cause (Final	ne cause on each line.	leath. Do not ent					Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a con		HOLEO	1 CT . (1)			
U.	peti l	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con		17800	311/3			
8/60,	cate be executed physician and the burial-transit	dicai Exa	that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
O. Box 68	that the death certifica led by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pregnance	у		23d. Date of de Month	elivery Day Year
<u>. </u>	Se un o	by	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.			to the cause of death? Probably 4 Dunknown
I Records,	The ate ha	Completed						24a. Was ar autops perform 1 Yes 2	ned? death?	autopsy findings available completion of cause of
VII	Physician: Th this certificate ral director, pag	o Be (25. Was case referred to medical examiner?	lospital:	GED/0	. 20 pos Ott	ar	ath (Check only one		2 - 610
lon of	nding Physician: ith. th. After this certific e funeral director.	H-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 EP/Outpatien 28b. Time of Injury	28c. Inju	4 🗆 Nulsing r	28d. Describe ho	nce 6 □Other (Spa w injury occurred	ecity)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, streecify)	eet, factory, office		28f. Location (Str. City or Town	eet and Number or F , State)	Rural Route Number,
	Hospii 24 hour Funer etely fill	edicai	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the tile restigation, in my c	me, date and place ppinion, death occu	e, and due to the ca urred at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	CONDING		29c. Licens	5056948		APAL 8	• • • • • • • • • • • • • • • • • • • •
(3		30. Name and address of person who co						TANSIND	
	Sta Registr	100	31. Date filed (Month, Day, Year) APR 1 2 200	1 1-	ignature		/	<u>/</u>		-

	EORGE 3	AII	1- State Registrar	State of Maryla	nd / Depa			lental Hygie		12426
	Physic /Med		1. Decedent's Name (First, Middle, Las George Samu	•	JR			2. Date of Death MARCH 1	4 ^{Day} 2005 ^{Year}	3. Time of Death 21:32 M
	Exami		4a. Facility Name (If not institution, give 2214 WEST NORTH A				or Location of Death		4c. County of Da	eth
	Funeral Director		5. Social Security Number 6. S. 212-23-5622 Usual Residence of Decedent	7. Age (In yr.	s. last birthday) 16 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y Nov • 7	,1988 B	inthplace (State or Foreign Country) alti. Md
	B Maryland	ctor	10a. State 10b. County Md N/A	10c. (Dity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23a or 28	Funeral Director	10e. Street and Number 2542 Loyola No:	rthway		10f. Zip Code	1215	10g	. Citizen of What C	Country?
9800	be filed within 72 hours after death with the Maryland hat Hyglene. Id other than "natural", or Items 23a or 28e-f show event, the Medical Examinar must be notified at	by	11. Marital Status 11. Never Married 2 Married 2 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 PNo If Yes, Give/Year or Dates:			Hispanic Origin? (Special, Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA 14. Race - Am Black, Wh Specify: BI	ite, etc.
1215-0	l within 72 hi lene. ' than "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	16a. Deced (Give life. I	dent's Usual Occu kind of work done OO NOT use retire	pation during most of working d)	ng 16	b. Kind of Business	s/Industry
Maryland 21215-0036	should be filed and Mental Hygle marked other lumatic event,	To Be Co	17. Father's Name (First, Middle, Last) George S	Smith Sr		N/A	18. Mother's Name	(First, Middle, Man	iden Sumame)A	
Baltimore, Mary	permit. Pages 1 and 2 should Department of Health and Mer Importent: If Item 27 is marks any Injury or other treumstic once.		19a. Informant's Name/Relationship (7. EVa Ellis gran 20a. Metbod of Disposition 1 Burial 2 □ Cremation 3 □ i 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Li ens	dmother Removal from State	254 Place of Dispos cemetery, crem	2 Loyol sition (Name of natory or other pla	^{ce)} 3/21	ay Bal ate 200 /2005 L	ity or Town, State, LLG Md c. Location - City or ansdown Park Hg	21215 Town, State e Md.
	Prrysician /Medical Examiner	iner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ications that caused the dealer cause on each line. A	WOLLA quence of):	er the mode of dyle	Gwynn FH ng, such as cardiac o head	Balto	Md 21	Approximate Interval Between Onset and Death
68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai Examiner		Due to (or as a conse	quence of);					
.O. Box	es that the death certific igned by the attending p be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of o 9 □ Unknown	aldeath 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
ords, P.	requires tha been signed hould be det	by	Part II. Other significant conditions con	atributing to death but not res	sulting in the un	derlying cause giv	en in Part I.		V	the cause of death?
Division of Vital Records,	Physicien: The faw r this certificate has t ral director, page 2 s	se Completed	25. Was case referred to medical				26. Place of Death	24a. Was an autopsy performed 1 A Yes 2	? prior to death?	utopsy findings available completion of cause of
ot >	Physici r this ce eral direc	To B	examiner? 1 X Yes 2 No 27. Manner of Death	ospital: 1	ER/Outpatient	3□ DOA Oth	er: 4 Nursing Hom		6 ∑ © ther (Special Control of the Control of t	city) SCENE
ision	ttending death. stor: Afte	Certification:	1 □Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	3-14-05	21:20 P	28c. Injun Work	Yes 2 No 5	ubject v	vas sh	
≥ O	spitel or A cours after nerel Direc filled in by		4 🕅 Homicide determined	28e. Place of Injury - At h building, etc. (Special CN - Hu from +	porch of	a dwell	ing A	City or rown, St	Ore 12	Nest North
	the Ho tin 24 h the Fur	Medical	one)	ner: On the basis of examina and manner stated.	ation and/or inve	estigation, in my of	pinion, death occurred	d at the time, date a	and place, and due	to the cause(s)
	\$ 1 8 E			v.D		29c. License			ARCH 15,	
	11		· · · · · · · · · · · · · · · · · · ·	mpleted cause of death (Iter	n 23a) (Type, P	111 Pe	nn Street	Baltimo	ore, Mary	land 21201
	Sta		31. Date filod (Month, Day, Year) APR 1 9 2001	32 Registrar's Signa	ature	-6				

			State of Maryland / Depa	artment of Health and Martificate of Death	-	2005 12427
	Physici: /Medic		Decedent's Name (First, Middle, Last) BONNIE LOU SUTHERLIN		2. Date of Death	2005 Year 3. Time of Death 5.05 A M
	Examin		4a. Facility Name (If not institution, give street and number) 4227 DORIS AVE.	4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
I	Funeral Director		5. Social Security Number 520-32-4513 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo Jan. 08,1	ear) 9. Birthplace (State or Foreign Country) Wyoming
	show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland N/A Ba	cation 1timore		10d. Inside City Limits 1 (Z Yes 2 ☐ No
	vith the N or 28a-1 be notifi	Director	10e. Street and Number 4227 Doris Avenue	10f. Zip Code 21225	10g.	. Citizen of What Country?
36	s after death v , or items 23s	y Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Varied Forces? 1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spef Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28a-f show wanty injury or other treumatic event, I're Medical Examinat must be notified at once.	Completed by Funeral	15. Decedent's Education (Specify only highest grade completed) [Give Ife.	dent's Usual Occupation kind of work done during most of workir DO NOT use retired) Omemaker	ng 16	b. Kind of Business/Industry Home
land 2	should be filed nd Mental Hygie marked other imatic event, III	To Be Co	17. Father's Name (First, Middle, Last) Lawrence Moore	18. Mother's Name		iden Sumame) e-Bennett
	and 2 sho eaith and I n 27 is me			ng Address (Street and Number or Rura) Alan Drive Apt. B		City or Town, State, Zip Code) Nore, Maryland 21227
Baltimore,	Pages 1 a nent of Hex ent: if Item ury or othe		20a Method of Disposition 20b. Place of Dispo	sition (Name of Date)	ate 200	c. Location - City or Town, State 1timore, Maryland
Balti	permit. Departn Importe eny in u		21. Signature of Fundal Service Licensee	Name and Address of Facility CCully-Polyniak Fu 237 East Patapsco	neral Ho Ave, Bal	me P.A. 21225 timore, Marvland
760, ×	American and was transit trans	l Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter thock, or heart failure. List only one cadse on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uncertifying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Current Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	er the mode of dying, such as cardiac of		Approximate Interval Between Onset and Death
.O. Box 68	death certific e attending p id for use as i	Physician/Medical		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
S, D	luires that the dea	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
I Record	The law requires that the sate has been signed by the page 2 should be detached.	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 \sum Yes 2 \sum No
f Vita	Physician: Th r this certificate ral director, paç	To Be	25. Was case referred to medical examiner? 1 Yes	26. Place of Death	44. 7	e 6 □Other (Specify)
Division of Vital	Attending Pt ir death. ector: After th by the funeral	atlon:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 1 Natural investigation	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred
Divis	et or Attenes s after death al Director: ad in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 2	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
	To the Hospitet or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death one) Certifying Physicien: To the best of my knowledge, death one) Certifying Physicien: To the best of my knowledge, death one) and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the caus ed at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
ŧ	To the within 2 To the complet	Σ	29b. Signature and file of certifier LED Color MD	29c. License number D 16354	AF	RIL II, 2005
	M.		30. Name and address of person who completed cause of death (Item 23a) (Type, EW COLE STAGNES 900)	Print) CATON AVE	BALT.	MD 21229
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la		

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State of Maryland / Department of Health and Certificate of Death		ene 005 2428
	Physic		1. Decedent's Name (First, Middle, Last) Nancy J. Schillings	2. Date of Death Month AF'RIL	Day Year 1 2 200 PM
	/Medi Examir		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Deat Tows	th	4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 214-30-7780 6. Sex 1 M 2 K F 7. Age (In yrs. last birthday) 70 Yrs. 1 Days Hours Min. 1 Usual Residence of Decedent	(Month, Day,)	year) 9. Birthplace (State or Foreign Country) 1934 Pennsylvania
	h the Maryland or 286-f ehow a rediffied at	irector	10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code	100	10d. Inside City Limits 1 ☐ Yes 25 No g. Citizen of What Country?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28e-f show other traumatic event, the Medical Evantinal must be rollined at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Year or Dates: 1 Never Married 2 Married Year or Dates:	Specify Yes or No- to Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	filed within 72 ho Hygiene. other then "natur ent, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 16a. Decedent's Usual Occupation (Give kind of work done during most of wo	rking	Self - Employed
Maryland	should be file and Mental Hy is marked othe aumatic event,	To Be C	William Bromiley Evely	ne (First, Middle, Mannan	, , , , , , , , , , , , , , , , , , ,
	s 1 and 2 st of Health and item 27 is n other traun		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rink Melinda McLean, Daughter 1416 Second Road Middl		
nore	0 0 == ==		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		oc. Location - City or Town, State
Baltimore,	permit. Pag Department Important: i any injury o once.		21. Signature of Funeral Service Live ee 22. Name and Address of Faculty Cremation Society	Of Maryla	
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. EMFHYSEMA resulting in death)	c or respiratory arres	t, Approximate Interval Between Onset and Death UNKNOWN
	Examiner		Due to (or as a consequence of): Sequentially list conditions, b.		
8760,	e be executed sician and e burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causes (Listens of Listens of Cause) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
al Records,		Completed		24a. Was an autopsy performe 1 ☐ Yes 2 ∑	
f Vital	Physician: 1 this certifical ral director, p	To Be	examiner?	ath <i>(Check only one)</i> Iome 5 Residence	ce 6
Division of	Ten Ten	ertification:	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28d. Describe how	injury occurred
Divis	o lifte	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and place 2 Medical Examiner: On the basis of examination and occurred at the time, date and the basis of examination and occurred at the time, date and the basis of examination and occurred at the time.	rred at the time, date	and place, and due to the cause(s)
)	To To Some	Σ	29b. Signature and title of certifier 29c. License number D 53464		Date signed (Month, Day, Year)
	b		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSON J. MARX. 76/21 OSLER DRIVE, TOWSON, MAR	YI AND 21	1274
	Sta Registr	200	31. Date filed (Month, Day, Year) APR 1 2 2005 APR 1 2 2005		

			Flease	Type or Print				_	-	
			1 For State	State of Mary				ental Hyg	iene 0 0 5	12429
			Registrar		Ce	rtificate of	Death		g. No.	I to I to d
	Physici	an	Decedent's Name (First, Middle, Last	1 5 1 10	150			2. Date of Deat Month	n Day Year	3. Time of Death
	/Medic		MARILYN (1	10h0/201	V -777	NCE		4 PRIL	7 Z00	
1	Examir	ier	4a. Facility Name (If not institution, give	9/1/		46. City, Town,	or Location of Death	_	4c. County of De	ath
			5. Social Security Number 6. Se	1/2W 10 A	yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	9 8	rthplace (State or Foreign
	Funeral Director		213-62-6551	DM 2MF 53		Months Days	Hours Min.	8. Date of Birth (Month, Day, 08 2.	1 53	MD
	and **		Usual Residence of Decedent 10a, State 10b, County	10	c. City, Town or L	ocation				10d. Inside City Limits
	Aaryl f sho	ō	MD Baltimo	ore	Catonsv	ille				1 ☐ Yes 2 No
	28a-	Director	10e. Street and Number	JLC ,	04.0	10f. Zip Code		10	Og. Citizen of What C	Country?
	3a or		1420 Adamazziou	Road		21	.228		U.S.	Α.
	ms 2	Funeral	1430 Adamsview 1	12. Was Decedent Ever	r in U.S. 13.		Hispanic Origin? (Spe- ban, Mexican, Puerto F	cify Yes or No-	14. Race - Am	erican Indian,
9	after or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 Xio If Yes, Give				rican, etc.)	Black, Wh	
8	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or tlems 23a or 28a-f show event, the Medical Exercities must be rediffed at	Completed by	3 ☐ Widowed 4XXX ivorced	Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:		Specify:	Black
5-0	72 h	etec	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Give	dent's Usual Occu kind of work done	during most of working	ng	16b. Kind of Busines:	s/Industry
2	within ene. than "	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire		0.76	Pouging	Authority
2	filed v Hygie other t		12th grade 17. Father's Name (First, Middle, Last)	4yrs	Child	Care C	loordinat			Authority
anc		Be							naloen Sumame)	
Maryland 21215-0036	⊇ ≥ 2 ± 2	은	Malvin Nichols 19a. Informant's Name/Relationship (7)		19b. Maili	na Address (Stree	Mary Ha		City or Town State	Zin Code)
Ma	12 h a 7		Ashley Lorenz-D				iew Road			'
ē,	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition	2	Ob. Place of Dispo		. D		20c. Location - City o	
JO.	0 0 = =		¹ Burial 2 ☐ Cremation 3 ☐ F ¹ 4 ☐ onation 5 ☐ Other (Specify)				Park 4/1	6/05	Randalls	town, Md
Baltimore,			21 Igna ur of Funeral Service Licens	Λ /	2:	2. Name and Addr	ess of Facility	The second second second second		00,111, 011.
ñ	permit. Departimport. any inj		Atome	H- show	Isn 4	368hw£6	H West ash Ave,	Balti	more, Md	21215
			23a. Part 1 Enter the disease, or complished, or heart tailure. List only o	lications that caused the		· · · · · ·				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1-1-0	-100	1/0	diovasco	1,00	Easo	Onset and Death
1	/Medical		resulting in death)	a. Due to (or as co	onsequence of):	1100118	CIUVISCU	WET 1	10	Jak
	Examiner		Sequentially list conditions,	b	-					1
	P =	ner	if any, leading to a mediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequanca of):					
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
760,	te be executed ysician and te burial-transit		rosuming in doubly East	Due to (or as a co	insequence or):					
687		dical		d				······································		
9 ×	ding p	Physician/Medi	IF FEMALE:	23c. If yes, outcome of pr	regnancy		district.		92d Date of de	line -
Вох	atten for us	ian	in the past 12 months?	1 Live birth 2 □ 4 Pregnant at time	Fetal death 3	Ectopic pregnance Other (specify)	СУ		23d. Date of de Month	Day Year
o.	at the de by the	iysic	1 □ Yes 2 🖼 No 9 □ Unknown	9☐ Unknown		_ cc. (apcony) _				
<u>α</u>	g g g		Part II. Other significant conditions con	ntributing to death but no	ot resulting in the u	nderlying cause g	ven in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
Records,	uires n sign	d by	0865,74					1 🗌 Ye	s 2□No 3 p	robably 4 Unknown
00	w requir been s should	lete	History	5 Loop A	Danco	<u>.</u>		24a. Was an		utopsy findings available
Re	The lav ate has page 2	Completed	1115,009 09	- Loop 12 1	610000			autopsy	prior to death?	completion of cause of
Vital		a)	25. Was case referred to medical				26. Place of Death		•	s 2 No
>	Physician: this certifical	OB	avam/nar?	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Ot	her: 4 \(\text{Nursing Hom} \)		nce 6 □Other (Spe	ecify)
) of	5 0 0	n:T	27. Man or of Death	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	f 28c. Inju			w injury occurred	
<u>ō</u>	Attending I r death. ector: After by the funer	atlo	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(10011111, 22)	a., mjury		Yes 2 □ No			
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S		eet, factory, office	2	8t. Location (Str. City or Town,	eet and Number or R , State)	ural Route Number,
	0 # 15 E	Cer								
	Hospitai 14 hours a Funerai l	edical	(Check only 2 Medicel Exami	sicien: To the best of my iner: On the basis of exa	ımination and/or ın	h occurred at the ti vestigation, in my	ime, date and place, a opinion, death occurre	nd due to the ca d at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within 2. To the I complet	Med	29b. Signature and title of certifier	and manner stated.		29c Licen	se number	20	d. Date signed (Mon	th Day Yearl
\	To Tool		29b. Signature and Little of certifier							* .
7	5		1 Welle 6	ense O	WP	Drien)	/11//	P	MICK 7, 2	005
	10		30. Name and address of person who of	Impleted cause of death	(Item 23a) (Type,	-/III)	PNE, ENL	10-5-1	die Ma	100/2 2
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registres	Signature	nush	Way Chl	, 0077	17,00	KYLAN)
18.	Registr		8DD 1	2 2005	en K	Gosel	7			2107-1

			1- For Amend Item 23a per Dr., 6842, Department of Health and M Certificate of Death	ental Hy	giene Reg. No.	05	2430
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Elsic Simm S	2. Date of D Month	Day	Z Oos	3. Time of Death 1940 M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	•	4c. Cc	ounty of Death	C.1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Birtho	place (State or Foreign
	Director		Usual Residence of Decedent	08 . 01 .	1420		MD
boalve Market	Marylar febow	ŗo	10a. State 10b. County 10c. City, Town or Location BALTIMORE				0d. Inside City Limits 1 4 Yes 2 No
	or 28a	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citize	n of What Cour	ntry?
	eath w	erai	619 N. GRANTLEY ST. 21229 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	cifv Yes or N	0- 14	. Race - Americ	can Indian,
36	be filed within 72 hours after death with the Marylan tal Hygliene. Id other then "naturelt, or items 23a or 28a-f show event, the Madical Examinar in that be notified at	by Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerto I □ Never Married 2 □ Married I □ Yes 2 ☑ No I □ Yes 2 ☑ No Specify:	Rican, etc.)		Black, White,	etc.
215-0036	filed within 72 hours after Hygiene. other then "neturel", or Ite ent, The Madical Examina	ted b	3 ☑ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working)	na	1	of Business/In	
	within 7 ane. then "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+) OTH GRADE N/A COOK	.9	NIHDS	SING H	OME
Maryland 21	e filed with al Hygiene. other ther vent, Ine N	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle			011/2
ylaı		70	HOWARD DORSEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	I Pouto Numi	or City or T	oum State Zir	Codo
Mai	od 2 alth a 27 I		DOROTHY HARDEN 929 KEVIN RD. BALTO		212	29	
ore,	0 0		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	ate		tion - City or To	
altimore,	Pa nen ent: ury		'4 Donation 5 Other (Specify) GARRISON FOREST 104.	5.05		GS MIU	s, mo
Ba	permit. Departr Importe any Inj		VAUGHN C. GREENE FUR 5151 BALD. NATL PIKE	NERAL :	SERVICE MD	至1229	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Terminal Aspiration Due to (or as a consequence of):		arrest,		Approximate Interval Between Onset and Death
	ş	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.				
8760,	ficate be executed physician and is the burial-transit	dicai Exa	resulting in death) Last C. Due to (or as a consequence of):				
9	ertifical ding ph	/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			4. Data of dali-	
.O. Box	the death certific y the attending p ched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Usive birth 2 Fetal death 3 Ectopic pregnancy 1 Ves 2 No 9 Unknown 1 Unknown 3 Unknown 3 Unknown 3 Unknown 3 Unknown 3 Unknown 3 Unknown 5 Unkno		230	Date of delive Month	Day Year
rds, P.	The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use Yes 2□I		ne cause of death?
Vital Records,		Completed		24a. Was auto perf 1 \subseteq Yes		24b. Were auto prior to co death? 1 🗆 Yes	psy findings available mpletion of cause of
Vita	sicien: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes			Other (Case)	
J Of	ding Phys h. After this o funeral dir	on: To	The res 22.10 In Impatient 2 2.20 Culpatient 3 DOA 4 Invuising non	28d. Describe			//
Division of	o the Hospitel or Attending Physicien: ifthin 24 hours after death. o the Funerel Director: After this certific ompletely filled in by the funeral director,	Certification:	2 Accident investigation M 1 Yes 2 No	28f. Location City or To	(Street and I wn, State)	Number or Rura	l Route Number,
_	To the Hospitel within 24 hours a To the Funerel completely filled	edical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the	cause(s) ar , date and pl	id manner as s ace, and due to	tated. the cause(s)
/	To the To the comple	Me	29b. Signature and title of certifier 29c. License number 17749		29d. Date s	igned (Month,	Day, Year)
(5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			10/0	- 5
	Sta	te.	Janu Carin ZZ 5. Greene 5+ 5/2D Bal 31. Date filed (Month, Day, Year) 32 Registrar's Signature	times	e, M	15 A	202
	Registr		APR 1 2 2005 Keeper & Aprile				

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. /	nysicia Medic xamin	al .	1. Decedent's Name LUCIL 4a. Facility Name (If I	not institution, gi	L, S	SMITH er)		4b. City, Town, o			2. Date of De Month A PRIC	7, 4c.	Ye 2 30 County of E	ear Someth	3. Time of Dea								
	neral ector		5. Social Security Nu 215-22-10	079 6.	(+05 P; TAL Sex 7. 1 □ M X F	Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days			8. Date of Bir (Month, Da 07/14/				e (State or For	reign							
Maryland	te beili	ctor	Usual Residence of I 10a. State MD	10b. County Baltim	ore	10c. City, T	fown or Lo							10d.	Inside City Lin								
with the	I be no	i Dire	10e. Street and Num 11 01d 7		Road			10f. Zip Code 211	17			-	en of Wha		?								
1215-0036 within 72 hours after death with the Maryland ene. sne	il Examiner mu	d by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 XWidowed 4	Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	SS? No s:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:		cify Yes or No Rican, etc.)		Specify:	White, etc	:e								
21215-0036 od within 72 hours aff giene.	the Medic	Completed		15. Decedent's E fy only highest gi idary (0-12)		or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired s Directo	during mosi d)	t of workin	g		of Busine		e Gove	rn.							
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan popuriment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural: or Items 23a or 28a-1 ahow	any injury or other trauma once.	- Constitution of	19a. Informant's Nar Carol S. 20a. Method of Dispo 1	Dadds osition Cremation 3 [5 □ Other (Spec	(Step-I	laughter 20b. Plac cem	c) 40 se of Disponentery, cres	7 Lakesic 7 Lakesic 8 Lakesic 9 Sistion (Name of matory or other place 1 Name and Address	le Dri	o4/1 Lori	Lewes, ale 1/05 ng Byen	Dela 20c. Loc Laur	ware cation City	199 yorTown Maryl L Dir	58 State	,In							
ate be executed visician and	ician dical mine principle	To Be Completed by Physician/Medical Exam	ical Exam	ical Exam	ical Exam	ical Exam	ical Exam	23a. Part 1. Enter the shock, or heart Immediate Cause (Fidisease or condition resulting in death) Samuentially list conditions and the shock of th	tailure. List only Final ditions, mediate lying	a	as a consequent as a consequent as a consequent as a consequent as a consequent as a consequent as a consequent	Do not ent	de ffice						A;	proximate terval Between nset and Death	h		
death certif	detached for use as		IF FEMALE: 23b. Was decedent in the past 12 m 1 Yes 2 9 Unknown	nonths?		2 ☐ Fetal de t at time of deat	ath 3	Ectopic pregnancy Other (specify)	,			2	3d. Date of Month	delivery Da	y Year								
ecords, P.O law requires that the	p eq		To Be Completed by	To Be Completed by	To Be Completed by	by	by	by	by ,	Part II. Other signific	cant conditions	contributing to deat	h but not re <i>s</i> ultir	ng in the u	nderlying cause giv	en in Part I.						ause of death	
The see	r, page 2 should																	1 ☐ Yes	med?	24b. Were prior death	to compl h?	findings availa etion of cause	able of
on of ding Phys	funeral di					25. Was case referre examiner? 1 Yes 2 No. 27. Manner of Death 1 No. 20 Accident 3 Suicide 4 Homicide	No	on 28e. Place of	njury 28 Day Year)	VOutpatier Bb. Time of Injury a, farm, str	28c. Injun World	er: 4□ Nu	rsing Hom 2	(Check only only only only only only only only	dence 6 now injury	occurred		oute Number,					
DIVISION TO the Hospital or Attend within 24 hours after death To the Funeral Director:	completely filled in	Medical Ce			hysician: To the be miner: On the basis and manner	s of examination																	
Tothe	comple	Me	29b. Signature and ti	hutso	mp.		3a) (Type,	29c. Licenso		973	6	Ay	signed (M	7.		. 195							
')	Stat egistra		DEG S RATE 31. Date filed (Month		32. Regi	strar's Signature	PORTI.	wer r	tospIT.	AL	5401	٥٠	0 4	JRT	RUAS	0							

			1 - State Unpend Item Registrar 1. Decedent's Name (First, Middle, I		Cei	tificate of	Death	2. Date of Deat	th	3. Time	32 of Death
	Physicia		Christophe	c M Joseph	100.			April 1	LO, 2005	_{ear} 0243	Ra M
	/Medic		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	r Location of Death	110111	4c. County of		<i>,</i> a
			Upper Chesapeake	Medical Center		Be1	Air		Harfo	ord	
	uneral irector		212.80.3530	Sex. 7. Age (In yrs. 1. Age (In yrs. 1. 2. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State Country)	
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with the	or 28s be noti	Direc	10e. Street and Number	il Pol		10f. Zip Code	14.0-	1	0g. Citizen of Wh	at Country?	
ath	s 236	rai	1835 Church		6 12	Man Donadant of b	/O/S	poits Vac or No.	14 Page :	American Indian,	
036 urs after de	Department or result and wonter rygiene. Department or result and wonter rygiene. Say injury or other treumatic event, the Medical Evertiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 Who If Yes, Give Year or Dates:		Was Decedent of P If Yes, specify Cubi 1 ☐ Yes 2 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		White, etc.	
Maryland 21215-0036 to 2 should be filed within 72 hours aff	"neture	pieted	15. Decedent's (Specify only highest of	grade completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	eation during most of work d)	ing	16b. Kind of Busin	ness/Industry	
Mith	tha	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Dix	Hed			NIA		
D post	othar ant.	BeC	17. Father's Name (First, Middle, La	st)	02,0	<u> </u>	18. Mother's Nam	e (First, Middle, I	Maiden Sumame)		
Tan Id be	ked icev	To B	Konnoth R	Dolton			815ie	Rosema	acu Ca	CC.	
ary shou	mat	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rug	A Route Number	City or Town, Sta	ate, Zip Code)	
Z pu	27 is		Elsie R. Malton	·).	7.13	liniter.	3 Mill K	1. Fore	St H.11.	MD 210	050
Baltimore,	item		20a. Method of Disposition	I ^	Place of Dispo	sition (Name of natory or other place		Date	20c. Location - Ci	ty or Town, State	
Page Page	ry of		1 ■ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Hemoval from State	1 0/	nocial Ga	11 1 11	13-05	Pol Hic	MD.	
HE HE	inju		21. Signature of Funeral Service L/8	ensee		2. Name and Addre	ss of Facility	vest Hil	1, MD 2		
ä ä	E E S		Kimber Vist	20 Motors	EI	AUS FOLKS		PEL 3K	,	-00	
			23a. Part1. Enter the disease, or co	mplications that caused the death	h. Do not ent	er the mode of dyir				Approxim	ate
			shock, or heart lailure. List on Immediate Cause (Final	ly one cause on each ine.						Interval Be Onset and	
	/sician ledical		disease or condition resulting in death)	a. Exsanguination Due to (or as a consequence)							
	aminer			bue to to as a consequence		Fracion/R	unture				
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pej	nsit	Examiner	Sequentially list conditions, it any, leading to introduct cause. Enter Underlying Cause (Disease or injury	c End Stave Rei	nal Di	2222				10	
60, be execu	sician and burial-transit	xai	that initiated events resulting in death) Last	Due to (or as a consequ		Scabe					
	siciar	. <u></u>									
687 tificate	phys s the	gic		0.							
. Box 687	ed by the attending phys detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	Ideath 3	Ectopic pregnancy	,		23d. Date of		Year
. 0	the shed	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5L	Other (specify)					
P.O.	igned by be detac	by Ph	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribu	ute to the cause of	death?
ords,	9 73		Cocaine Intoxica	tion				1 □ Ye	es 2□No 3	☐ Probably 4	Unknown
eco law re	as been 2 should	Completed						24a. Was a	n 24b. We	re autopsy finding or to completion of	s available
	age 2	mo						autops perform	ned? dea	itb? Yes 2□ No	cause of
Be a	iffical	0	25. Was case referred to medical				26. Place of Deat			7763 2010	
tal Re		O B	examiner? 1∑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 🔀	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing Ho			(Specify)	
Vital Re	s cer direc		27. Manner of Death	28a. Date of Injury (Month, Day Year)		unk 28c. Injur	y at		ow injury occurred		
of Vital Re	er this cer eral direc	-		(Month, Day rear)	injury		Yes 2 No				
on of Vital Re	: After this cer funeral direc	-	1 Natural 5 Pending	ion 4-10-05				291 Location /St	reet and Number		
Vision of Vital Re	ractor. After this cer by the funeral direc	-	1 Natural 5 Pending	28e. Place of Injury - At ho	ome, larm, str	eet, lactory, office		City or Town		or Rural Route Nu	
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State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

111 Penn Street

Baltimore, Maryland 21201

DE

TOLLAK

32. egistrar's Signature

30, Name and address of person who completed cause projecth (Item 23a) (Type, Print)

2005

Year)

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 1 per phys 2842 4-13-05 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Ruth Swope Decedent's Name (First, Middle, Last) Irene 2. Date of Death 3. Time of Death Day Month Year **Physician** AM 1:00 10 2005 Fecility Name (If not institution, give street and number, /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WRITA 4.MCRE HOPKINS DHNS 7. Age (In yrs. last birthday If Under 1 Year Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 219 01.4070 Hours 1 M 2 F Macilano 0.12.1919 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show dried rount be notified at 1 Yes 2 No Director SALTIMORE MONIUM 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12. Was Decedent Ever in U.S.
Armed Forces?
1 | Yes 2 | No If Yes, Give Year or Dates: 2300 Du USA 21093 Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 À Specify: WHITE other traumatic event, the Musical Example 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) F-DUCATION ECRETARY 12 should be filed w h and Mental Hygien 7 is marked other th 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) TRENE MCNUI LEGGET KUTH HILARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) perriit. Pages 1 and 2 sh Depirtment of Health and Important: ff Item 27 is n any injury or other traum once. IRENE RUTH STEVENS, DAYSHTER 3034 ARIZONS AVE. PARKULLE, MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State EVANS FUNERAL CHARE 4-12-05 CEST HILL, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility EVANS CHARL OF MEMORIES 21. Signature of Funeral Service Licensee 8800 HARFED RD FACKULLE, ND 21234 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of); d441 HENORRHAGE /Medical **Examiner** RATORY Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-transit CPSIS to (or as a consequence of) 68760, the attending physician hed for use as the buria Physician/Medical CARDIA IF FEMALE Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown á ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 🗆 No 2- No 1 Yes of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ō within 24 hours a To the Funeral D Hospital 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier T4538 30. Name and address of person who cg npleted cause of death (Item 23a) (Type, Print) 4.6001 Hauley, Jason S 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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-			For Stata Registrar	State o	of Marylar		partment of H			iene 005	12435
			1. Decedent's Name (First, Middle	, Last)	-	-			2. Date of Death Month	h Day Yea	3. Time of Death
	Physici /Medio		June	Lee	2		Shelton		April	6,200	5 5:20 PM
	Examin		4a. Facility Name (If not institution	, give street and nu	mber)	4	P3 .	Location of Death	-	4c. County of De	ath
			North Aru	ndel H	05Pita	1	Glen	burni	le	Annel	trundel
	Funeral		5. Social Security Number 236–26–1168	6. Sex 1 ☐ M 2 🛣 F	7. Ağe (İn yrs.	last birthda, Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		84	115.			June 15,	1920 Ke	ntucky
	and w		10a. State 10b. County		10c. Ci	y, Town or	Location				10d. Inside City Limits
	Marylan f show	ō	MD Anne	Arunde1		Severn					1 ☐ Yes 2 XNo
	the Ma	Je C	10e. Street and Number	Arunder		CVEII	10f. Zip Code		10	og. Citizen of What (Country?
	3a or	<u> </u>	321 Council Oa	k Drive			2	1144		USA	
	after death with the Maryla or Items 23a or 28a-f shov	era	11. Marital Status	12 Was Dec	edent Ever in U	.S. 13	B. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe	ecify Yes or No-		nerican Indian,
ဟ	or Ite	Ξ	1 ☐ Never Married 2 ☐ Marr	Armed Fo	orces? 2 M No		1 ☐ Yes 2 X No	Specify:	Hican, etc.)	Black, Wi	White
7.6 5-0036	ral',	d b	3 ☐ Widowed 4XXDivorced	If Yes, Gr Year or D	Dates:		1 195 220 140	зресну.		Specify:	WIIICE
£ 5	within 72 hours after death with the Maryland one. and "natural," or Items 23a or 28a-f show the Mudical Evandrar must be notified at	Completed by Funeral Director	15. Decedent (Specify only highest			16a. Dec	edent's Usual Occup ve kind of work done o . DO NOT use retired	ation during most of worki	ing 1	16b. Kind of Busines	s/Industry
1 7 2	within ene. than '	ם	Elementary/Secondary (0-12)	College (1-4or 5+)			3)		II G -	
7	_ ~ _ ~		12 17. Father's Name (First, Middle,	l act)		Lare	Giver	18. Mother's Name	/First Middle N	Human Se	rvices
	d be f	To Be	Dillard McGra				-		ha Green	•	
$\Rightarrow \Xi$	2 should be f and Mental b is marked of raumatic eve	ř	19a. Informant's Name/Relations			19b Ma	iling Address (Street				Zip Code)
Shelton lore. Marvla	ges 1 and 2 should be filed t of Health and Mental Hyg If Item 27 is marked othe or other traumatic event,	113	Sandra Rushfor		ter)	1	COUNCIL				
E E	ss 1 and 2 of Health Item 27 i		20a. Method of Disposition		20b. F	_	position (Name of ematory or other place			20c. Location - City of	or Town, State
S 6	Pages nent of I int: If Its		1 Burial 2 remation 4 Donation 5 Other (S		State		rematory	4-9-0	05	Baltimore	, MD
She Baltimore.	permit. Pages Department of H Important: if Ite any injury or of	1	21. Signature of Funeral Service		1		22. Name and Addres	ss of Facility			,
ä	permi Depa Impo any ii		Just A	all		+	Hardesty 12 Ridge	y Funéral ely Avenue	ноте, Р e, Annap	.A. olis, MD	21401
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on (caused the deat	h. Do not e					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	,	C.	000	bral D	extanct	2 /2		Onset and Death
	/Medical		resulting in death)	a. Due to	(or as a consec	uence of):	D3_V1	1.0101	7013		1407
	Examiner		Sequentially list conditions.	b							
	p tis	Examiner	Sequentially list conditions, if any, leading to infiltediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a nonseq	uence ot):				``	
	and and I-tran	хаш	that initiated events resulting in death) Last	c. Due to	(or as a conseq	neuce of).					
8760.	cate be executed by sician and the burial-transit				(0. 40 4 40						
387	phys phys	g		d							
Box 6	h certific anding p use as	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregna	ancy				23d. Date of d	elivery
B	death atter	ciar	in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	4□Pregr	birth 2 Feta nant at time of d		□Ectopic pregnancy □ Other (<i>specify</i>)			Month	Day Year
P.O.	t the c by the achec	Physician/Medical	9 □ Unknown	9□ Unkn	iown						
ű	res that the death signed by the atter I be detached for u	by P	Part II. Other significant condition	ns contributing to d	leath but not res	ulting in the	underlying cause give	en in Part I.	23e. Did tob	- 4	to the cause of death?
ģ	w require been sig should b	ed							1 🗌 Yes	s 2.25,No 3⊡I	Probably 4 Unknown
ပိ	aw re as be 2 sho	Completed							24a. Was an autopsy	24b. Were	autopsy findings available completion of cause of
œ.	The tage page	E O							l perform	ied? death? ☑No 1☐Ye	s 2🔼 No
/ita	clan: artific actor,	Be (25. Was case referred to medical examiner?	100				26. Place of Death	(Check only one	9)	
<u></u>	hyslo his co	မ	1 ☐ Yes 2 No		1	ER/Outpati		4 Nursing Hor		nce 6 Other (Sp	ecify)
<u></u>	ding Physician: After this certific funeral director,	inol.	27. Manner of Death 1	9 .	of Injury th, Day Year)	28b. Time Injury	Worl		28d. Describe how	w injury occurred	
Sic	ttend death itor: /	cat	2 Accident investig	and he	a of loiun At h	omo farm		Yes 2 □No	28f Location /Str	eet and Number or I	Rural Route Number,
Division of Vital Records,	or A after Direc	Certification;	4 Homicide determ	ned buildi	ing, etc. (Specif	y)	street, factory, office		City or Town,	State)	
	s Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. 2 hours after death. 3 Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit						ath occurred at the time				
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	one)	and man	nasis of examina iner stated.	uon and/or	investigation, in my o				
	To t To t	2	29b. Signature and title of certifier	18	10-1		29c. Licenso	e number	29	d. Date signed (Mor	A GO
	d		1/100	MA			(b).	5/15)	1	1001	p, WUS
	1		Nahar and address of person	wno completed caus	se of death (Item	1 23a) (Type	HOCA]	LOMI	DE FL	Burn	nd-71067
	Sta	te_	31. Date filed (Month, Day, Year)	32	legistrar's Signa	ature	parti	VI WII	11-10-17	11 MANUAL	. 0100/
	Registr		APR 12	2005	10450 1	G Je	1000				

			1 - For State Registrar AMEND ITE	M #20b PE	Maryland / Dep	partment of F	lealth and I Death	Reg.	4000	12436
	Physici /Media		1. Decedent's Name (First, Middle, Gerald Houst	· ·	ffer			2. Date of Death A Month	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution,		er)		r Location of Death	-	4c. County of Dea	ith
	Funeral		,	. Sex 7.	Age (In yrs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Birth	O Bi	thplace (State or Foreign ountry)
	Director		212 34 5958 Usual Residence of Decedent	MAXM 2□F	67 Yrs.	Moritis Days	Hours Min.	April 23,	1937 Ma	ryland
	Maryland s-f show	tor	10a. State 10b. County Maryland N/	A	10c. City, Town or Balt:	Location imore				10d. Inside City Limits Yes 2 □ No
	th with the 23a or 28a	al Director	10e. Street and Number 425 West 24th	Street		10f. Zip Code 21	211	10g.	Citizen of What C USA	ountry?
336	72 hours after death with the Maryland Instural', or itame 23e or 28e-1 show digal Exercitive must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3€ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 1 Yes 2 If Yes, Give Year or Date	ent Ever in U.S. 13 es? No es:	Was Decedent of H If Yes, specify Cuba 1 Yes 20XNo		pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	be filed within 72 hours after death with the Marylan lat Hygiene. Id othar than "natural", or itama 23a or 28a-1 show evant, the Medical Exactiver must be netitled at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education	16a. Dec (Giv (ife.	edent's Usual Occup re kind of work done DO NOT use retired ndscaping	during most of wor	king	Kind of Business	Vindustry Sisters
land 2		To Be Co	17. Father's Name (First, Middle, La Joseph E. Sha		140	idocuping	18. Mother's Nam Mae E	ne (First, Middle, Maid lizabeth W		5152015
			19a. Informant's Name/Relationship			ling Address (Street 425 West 2		ral Route Number, Cit et Baltim		Zip Code) yland 21211
Baltimore,	Pages nent of int: if if		20a. Method of Disposition 1 Burial 2XXCremation 3 4 Donation 5 Other (Spe			ematory or other plac		Date 20c. 4,2005 I.J	Location - City or	
Balt	permit. Departn Imports any inje		21. Signalus Funeral Service Li	expertu		3urgee-Her 3631 Falls	ss Facility ISS-Seitz Road, B	Funeral H altimore,	ome, Inc Maryland	. 21211
	Pnysician /Medical		23a Pan1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. LUNC	G CANCEL		g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	-ia	Sequentially list conditions, if any, leading to immediate cause. First Underlying	P. PNEU	as a consequence of): TO INDIA as a consequence of):					2 MECKS
o,	te be executed ysician and ie burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. CHRO Due to (or:	as a consequence of):	prultive	Pun	mam Di	SEASE	inmon N
8760,	physicis the bu	dical		d						
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		i 2 ☐ Fetal death 3 tat time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
٥.	w requires that t been signed by should be deta	by	Part II. Other significant conditions	contributing to death	h but not resulting in the	underlying cause gre	en in Part I.	23e. Did tobacci		o the cause of death?
Vital Records,	The ate h page	Completed						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	0 T CD (0	ont 35 DOA Oth		h (Check only one)		
ion of	ling After fune	tion: To	27. Manner of Death Natural 5 Pending Accident investigat			of 28c. Injury Work	4 Nursing no	ome 5 Residence 28d. Describe how in		cify)
Division	tal or Attendii s after death. al Diractor: A ed in by the fu	Certification;	3 Suicide 6 Could not 4 Homicide determine	d 280. Place of	Injury - At home, farm, s etc. <i>(Specify)</i>	treet, factory, office		28f. Location (Street City or Town, Sta	and Number or Ri ite)	ural Route Number,
	To the Hospital or within 24 hours after to the Funeral Direction Completely filled in the compl	Medical	(Check only 2 Medical Ex	Physician: To the be aminer: On the basis and manner	st of my knowledge, deas of examination and/or i stated.	nvestigation, in my o	pinion, death occur	red at the time, date a	nd place, and due	to the cause(s)
)	T with	~	29b. Signature and title of certifier		R,MC		43 89 16		Date signed (Mont	,, ,
F	5		30. Name and efficess of person who TACOS M. WIS SE	CUR, MO	UNIONME		SCITAL Z	DIE UNIVO	12187 Pkny	1. BALTINERE 21219
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 20	32 Regis	strar's Signature	West of				

			1 - State of Maryl Registrar		artment rtificate			and M	lental Hy	giene Reg. No.	005	12437
	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of De	eath Day	Year	3. Time of Death
	/Medi	cal		Slye					April	10	, 200.	5 1:30 P ^M
	Examir	ier	4a. Facility Name (If not institution, give street and number) Larkin Chase		4b. City, To		Location o	f Death			County of Dea	
	Funeral	-		rs. last birthday)	If Under 1		If Under 2	24 Hrs.	8. Date of Bir	rth	nce Geo	
	Director		577*30*9270 1□M 25□F 94		Months	Days	Hours	Min.	8. Date of Bir (Month, Da Dec • 19	ay, Year)	10 Is	thplace (State or Foreign ountry)
	pue *		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	nation							
	Maryla f sho	0	1/5	Upper Ma								10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	r 28a-	Director	10e. Street and Number	эррст на	10f. Zip C					10a, Citiz	en of What C	
	th with	al D	1723 Cinnamon Teal Way			20	0744				ed Sta	•
	r dea	ner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Deceder	nt of His	spanic Orig	in? (Spe	ecify Yes or No Rican, etc.))- 1·	4. Race - Ame Black, Whi	
36	s afte , or it	by Funeral	1 Never Married 2 Married 1 Yes 2 No		1□Yes #		Specify:	, , , , , , , , , , , , , , , , , , , ,	induit, did.)		Specify: B1	
8	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23a or 28a-f show event, Ite Modical Examiner must be notified at	edb	3 ₩ Widowed 4 □ Divorced Year or Dates:	16a Decer	dent's Usual (Occupa	tion				d of Business	
212	hin 72 an "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work DO NOT use	done di	urina most	of worki	ng	TOD. KIII	d of business	industry
7	ygien ygien iar tha t, the	Соп	12	Car	egiver					Dom	estic	
and and	be fill htal H ad oth	Be	17. Father's Name (First, Middle, Last) James Hawkins			- 1			(First, Middle,		Sumame)	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Menial Hygiene. Is marked other than "natural", or itams 23a or 28a-f show aumatic evant, the Madical Examinat must be notified at	၉	19a. Informant's Name/Relationship (Type, Print)	105 14-16-					Jenkins			
	and 2 s Balth an n 27 is I		Olivia V. DeWitt/ Niece	1723	Cinnai	non	Teal	Wav	Route Number	er, Crty or ≏ Man	<i>Town, State, .</i> 1 horo	Zip Code) MD 20744
Baltimore,	一工事芸		20a. Method of Disposition 20th	Place of Disno	sition (Name	of			ate		ation - City or	
Ē	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	t. Linco	oln Cei	nete	gry	4/1	5/2005	Brei	ntwood	, MD
<u>a</u>	permit. Pages Department of Important: If ii any injury or o		21. Signature of Funeral Service Ligensee						t Linco			
<u></u>	907 29	15	Dechard /horgs =						ad Bre		od, MD	20722
П			23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.	eath. Do not ente	er the mode o	of dying	, such as c	ardiac o	r respiratory a	rrest.		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Alzheimer		ise							Onset and Death Years
	Examiner		Due to (or as a cons Carcinoma		at							
i.		Jer			ist							Years
	cuted nd ransit	Examiner	day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	erostic	Heart	Dis	ease					vears
Ď,	и ехе sian ar urial-t		resulting in death) Last Due to (or as a cons	equence of):								
9/8 9	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dical	d									
X	eath certific attending p I for use as	Physician/Me	IF FEMALE: 23h Was decedent program 23c. If yes, outcome of pre-	onancy								- 2 34
POX	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at time of the past 12 months?	etal death 3 🗌	Ectopic pregi					23	d. Date of del Month	Day Year
r Ö	that the de led by the detached	hys	9 ☐ Unknown 9 ☐ Unknown									
-	res tha signed be det	by P	Part II. Other significant conditions contributing to death but not r	esulting in the un	derlying caus	e given	n in Part I.		23e. Did to	obacco use	contribute to	the cause of death?
	w require been sig should b								1 🗆 Y	/es 2 🕞	No 3□Pr	obably 4 Unknown
Kecords	law as b 2 si	ompieted							24a. Was autop		24b. Were au	topsy findings available completion of cause of
	Th ate pag	O							perfor 1 ☐ Yes	med? 2 ☑ No	death? 1 ☐ Yes	
Vital		o Be	25. Was case referred to medical examiner?			Other			(Check only o			
ō	y Phys ar this aral di	P-14	27. Manner of Death 28a. Date of Injury	ER/Outpatient 28b. Time of		Injury a	4 LP NUIS		e 5 ☐ Resid 8d. Describe h			cify)
0	nding ath. r: Afte e fun	ation	1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	М		es 2∐No			,,		
UNISION	r Atta	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, stre	et, factory, of	fice		2	8f. Location (S City or Tow	Street and I	Number or Ru	ral Route Number,
	urs aft ral Di							1				
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Medical Examiner: On the basis of examiner of examiner on the basis of examiner of exa	nowledge, death nation and/or inv	occurred at t estigation, in	he time my opir	, date and nion, death	place, a	nd due to the d d at the time, d	ause(s) ar	nd manner as lace, and due	stated. to the cause(s)
	o the	Med	one) and manner stated. 29b. Signature and title of certifier				number				signed (Month	
	0		KaKeshoun	Mam	D -	D	20	10	<i>6</i> 0	41	11/04	
K	1		30. Name and address of person who completed cause of death (It	em 23a) (Type, F	Print)			•			7-	
5			14300 Gallant Fox Lane Sui	te 222	Bowie	, MI	2071	15				
	Stat Registra	_	31. Date filed (Month, Day, Year) APR 1 2 2005									
			FILL TO COUL PROPERTY	20 15	CHOSALL	1						

		1 - For State Registrar	State of Ma	ryland /		rtment of F		nd Mental Hy	ygiepe Reg. No.	43 43	12438
		Decedent's Name (First, Middle, Landson L	ast)					2. Date of D	eath		3. Time of Death
Physici /Medi		James Robert	Smith, S	Sr.				April	. 7, Day	2005 Year	5:00 P M
Examir		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, o	r Location of	Death	4c.	County of Death	1
		2232 Castleton R	oad			Darling				Harford	
Funeral Director		5. Social Security Number 6. 230–62–1664	Sex 7. Age	(In yrs. last b	Yrs.	Months Days		Hrs. 8. Date of B Min. (Month, D July	irth ay, Year) 10,	9. Birth Cou 1946 Vir	place (State or Foreign Intry) Ginia
pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside City Limits
Maryli f sho	ō		a								1 ☐ Yes 2X No
288-	rect	Maryland Harfor 10e. Street and Number	u	Darli	iigto	10f. Zip Code		31.11.11.1	10g. Citi	izen of What Cou	intry?
h with	Ö	2232 Castleton R	oad			21034			τ	USA	
pormit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then *natural', or Items 23a or 28a-f show any Injury or other treumatic event, Ite Modical Examinat must be nuitled at once.	Funeral Director	11. Marital Status 1 □ Never Married 2 🛣 Married	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give		lf.	/as Decedent of H Yes, specify Cuba	dispanic Originan, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race - Amer Black, White	
ural;	d by	3 Widowed 4 Divorced	Year or Dates:	1						W	hite
nat nat	Completed	15. Decedent's 8 (Specify only highest gi	ducation rade completed)	16	(Give k	ent's Usual Occup rind of work done O NOT use retire	durina most a	of working	16b. Ki	ind of Business/II	ndustry
withir ene.	dwc	Elementary/Secondary (0-12)	College (1-4or 5-	+)		enter	-/		Cor	nstructi	on
filled Hygi other		17. Father's Name (First, Middle, Las	t)		Carp	CIICOI	18. Mother's	s Name (First, Middl			
lid be lental ked i	To Be	James Edmons	on Smit	-h			Annie	Mae	T	Wyatt	
shou and N s mai	-	19a. Informant's Name/Relationship			b. Mailing	Address (Street		or Rural Route Num.			ip Code)
and 2	11 8	Linda L. Smith -	Wife	2	2232	Castleto	n Road	l, Darling	ton,	Marylan	d 21034
of He of He		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 [Removal from State	20b. Place cemet	of Dispos ery, crem	ition (Name of atory or other plac	ce)	Date	20c. Lo	ocation - City or T	own, State
Pag ment ent: I		`4 □Donation 5 □ Other (Spec		Bel A	ir M	em. Gard	lens 4	1/11/05		Air, Ma	
Departition on the color.		21. Signature of Funeral Service Lice	insee			Name and Addre					me, P.A.
		Miller (! New	14	Ab - d - Ab - D						Alr, Ma	ryland 2101
		23a. Part1. Inter the disease, or shock, or heart failure. List	one cause on each lin	the death. Do				ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ance		so phage	LR.				6 min las
Examiner			Due to (or as a	consequence	e of):	, 0					
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as a	consequence	e of):						
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
icate be executed physicien and sthe burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence	e of):						
ate be nysicii he bu	dicai		d								
ertifica ing pt	Med	IF FEMALE:				_					
he death certific the attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal deat		Ectopic pregnancy	/		4	23d. Date of delive Month	∕ery Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at i 9⊡ Unknown	time or death	2□	Other (specify)		-			
w requires that the de been signed by the should be detached		Part II. Other significant conditions	contributing to death bu	t not resulting	in the un	derlying cause giv	ren in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
uires uires sign ld be	d by							10	Yes 2	□No 3□Pro	bably 4 Dunknown
w requir been si should	Completed							24a. Wa	s an	24b. Were aut	opsy findings available
he la he has age 2	mc							aute per	opsy formed?	prior to co death?	ompletion of cause of
vital nevidicien: The lav	S	25. Was case referred to medical					26 Place o	1 ☐ Yes of Death (Check only	20 No	1 🗆 Yes	2 52 No
yslcie s cert direct	0 0	examiner? 1 ☐ Yes 2-2 No	Hospital:	nt 2 ER/C	Outpatient	3□ DOA Oth	ar	ing Home 57 es		6 □Other (Speci	ify)
g Physical this neral dil	T iu	27. Manner of Death	28a. Date of Injury (Month, Day	y 28b.	. Time of Injury	28c. Injur Wor	y at	28d. Describe			,,
ath. Be fur Af	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	on	, , ,	пдагу		Yes 2 □ No				
al or Atte	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ry - At home, . (Specify)	farm, stre	et, factory, office			(Street an own, State		ral Route Number,
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-lansit	Medical (29a. Certifier (Check only one) 1 Certifying P	hysician: To the best o miner: On the basis of and manner stat	examination a	ge, death and/or inve	occurred at the tirestigation, in my c	ne, date and pinion, death	place, and due to the occurred at the time	e cause(s) , date and	and manner as I place, and due	stated. to the cause(s)
To th To th	M	29b. Signature and title of certifier	MD			29c. Licens	e number	7	29d. Dat	te signed (Month)	. Day, Year)
6		30. Name and address of person who	completed cause of de	eath (Item 23a	(Type, P	Print) 120 A) Bi	ELAIR	M) 210	14
St	ate	31. Date filed (Month, Day, Year)		r's Signature	-0 %		/)		0-10	
Regist	rar	APR 12	2005	30	A hos	SAN B					
DHMH 17 Rev 1/2	2001		The said of the sa	OR	IGINA						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death SMT TH **Physician** EGGY MARIE 9:56 AM Apri 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore N/A Harbor Hospital Center 8. Date of Birth (Month, Day, Year) NOV • 21 , 1 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 6 F 64 Vrs 214 38 7638 Director 1940 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinet must be notified at once. 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ▼ No Directo Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 211 Seward Avenue 21225 U.S. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disability Claims Officer years Social Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cecelia Agnes Goddard John Weldon Smith Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Smith / Brother 211 Seward Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Cedar Hill Cemetery 14/9/2005 ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Full eral Service 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastric (Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 Weeks DIGHON Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Cher (specify) P.O. 1 ed by the a detached f been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate 1 Tyes Division of Vital 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: ٩ 1 ☐ Yes 2 ♠ No 1 B Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA After the 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending death. 1 Tes investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral E 29a. Certifier 🗎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) April 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Hanover ST Baltimore MD Reza Cohari 3001 31. Date filed (Month, Day, Year) 32. segistrar's Signature APR 1 2 2005 Registrar

05-02452 amend item#19a, perFH, G42, 4/12/05 III
State of Maryland / Department of Health and Mental Hygiene Mark I. Shapiro **RJD** 1- For Unpend Item 23a,27,28a-f per me (1914) 4-28-05 tas Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 7, Day 2005 **Physician** 2143P. SHAPIRO MARK /Medical 4a. Facility Name (If not institution, give street and number) 3312 Smith Avenue 4b. City, Town, or Location of Death 4c. County of Death Examiner Pikesville Baltimore 8. Date of Birth
JULY 18,1951 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 **№** M 2 🗆 F 53 Yrs MD Director 212-60-6276 Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE PIKESVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or any injury or other traumatic avant 3312 SMITH AVENUE 21209 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER F00D 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SHAPIRO LE0 MINA WASSER ပ 19a. Informant's Name/Relationship (Type, Brint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELVIN SHAPIRO 3302 JANELLEN DRIVE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State *4 □ Donation 5 □ Other (Specify)

21. Signal le | Fuleral Service Licensee BETH JACOB CEMETERY 04/10/2005 FINKSBURG, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mixed Drug(Sertraline,Carisoprodol,Meprobamate)intoxication /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-translt death certificate be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes Division of Vital Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Scene 2 1 X Yes 2 ☐ No 28a. Date of Injury

Found:

Tound:

Tound:** 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Found: P death. 1 ☐ Yes 2 No 2 Accident Subject took drugs in by the 4-7-05 Diractor 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3312 Smith Avenue Pikesville, Baltimore County, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found: residence within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) April 8, 2005 29b. Signature and title of certifie 29c. License number OCME who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

Registrar

State

31. Date filed (Month, Day, Year) 32. egistrar's Signature APR 1 2 2005

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			1 - For State Registrar	State of Marylar	•	ent of Health		ntal Hygie	C 0 1	05 1244	
	Physici		Decedent's Name (First, Middle, La TYRONE	ist)	TRU	ISTY		PRIL	Day	Yeer 9:30 P	N
)	/Medio Examir		4a. Facility Name (If not institution, given THE JOHNS HOPK)		1	City, Town, or Location	n of Death	-4	4c. County of		
No.	Funeral Director		5. Social Security Number 6. 5	Sex 7. Age (In yrs. 57		nder 1 Year If Unde		Date of Birth (Month, Day, Ye	948	9. Birthplace (State or Foreign MARY LAND	חון
	Maryland -f ahow	tor	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location	HTIMORE	~			10d. Inside City Limit:	
	death with the Maryland ms 23a or 28a-f show rnust be multing at	Funeral Director	10e. Street and Number 448 F. LOR	RAINE AVE	10	Zip Code	218	10g.	Citizen of W	/hat Country?	
20	s after deatl ; or Items 2	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		ecedent of Hispanic C specify Ouban, Mexic es 21/2 No Specif		fy Yes or No- can, etc.)		American Indian, K, White, etc.	
00-617	i within 72 hours after death with the Maryla liene. I than "netural", or Items 23s or 28s-1 show The Madical Examinar must be nutified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	(Give kind o	Usual Occupation of work done during me of use retired) VNSLER	ost of working	166		siness/Industry	_
lana z	uld be fited w Mental Hygie rked other t tic event, th	o Be Co	17. Father's Name (First, Middle, Las. ANDREW	TOHNSON	Co		ther's Name (i	First, Middle, Mai			
baitimore, mary	permit. Pages 1 and 2 sho Department of Health and I Important: If Item 27 Is me any injury or other traums anges.		19a. Informant's Name/Relationship Description 20a. Method of Disposition 1 Burial 2 Cremation 3 0 ther (Speci	Pusty WIFE 20b. Removal from State KIN	448 E	or other place)	Date of the positive of the po	E. BACT B.OS B THN C.E	THOKE Location - PACTIM TREENE	MO 2/2/8	Ve
)	Physician /Medical Examiner		23a. Part1. Enter the disease, of che shock, or heart failure. List only transdiate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. MULTI SYST Due to (or as a consect b. SEPSIS	EM 0RG4 quence of):	, -	as cardiac or r		, Iwas	Approximate Interval Between Onset and Death 2 DAYS 2 DAYS	_
9/00,	cate be executed oblysician and the burial-transit	dical Examiner	r any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	C			-				
O. Box 6	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	aldeath 3⊟Ectop	oic pregnancy r (specify)	-		23d. Date Mon	e of delivery th Day Year	
ras, r	requires that the een signed by th hould be detache	þ	Part II. Other significant conditions	contributing to death but not re-	sulting in the underly	ing cause given in Par	t I.	23e. Did tobac 1 ☐ Yes		bute to the cause of death? 3 ☐ Probably 4 ☐Unknow	'n
Vital Records,	The lar ate has page 2	Completed						24a. Was an autopsy performed	? de	Vere autopsy findings available fior to completion of cause of eath?	0
	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ⊠ Inpatient 2	ER/Outpatient 3[Othor		Check only one) 5 ☐ Residence	a 6 ∏Othe	or (Specify)	_
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DIVISION	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not to determined		nome, farm, street, fa	ctory, office	28	f. Location (Stree City or Town, S		or or Rural Route Number,	
	e Hospi 24 hou e Funer letely fill	edical		hysician: To the best of my kniminer: On the basis of examinated and manner stated.							
	To the within To the	Me	29b. Signature and title of certifier	0		29c. License numbe				(Month, Dey, Year)	
	of				M.D.	RES-0	00	AP	RIL (6, 2005	
,) ·		30. Name and address of person who CHARLES GALANIS			REET B	ALTIMO:	RE MAR	YLAND	21287	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign				,			

ORIGINAL

		•	State of Maryland / Department of Health a 1- State Registrar Certificate of Death		l Hygier	201)5	12442
	Physicia		1. Decedent's Name (First, Middle, Last) Louise M. Thomas	2. Date Mor	of Death)ay 7	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of			4c. County	of Deeth	0.13
	LXdiiiii	·	Stella Maris - Mercy Hospital Baltimore					
	Funeral		5. Sociat Security Number 6. Sex 7. Age (<i>In yrs. last birthday</i>) tf Under 1 Year tf Under 2 1	Min. 8. Date	e of Birth nth, Day, Yea V . 9 , 1	ar) .	9. Birthpi Coun	lace (State or Foreign
	Director	-	216-56-4254 1 M 20 F 87 Yrs. Molitis 243 Tours World 1	No.	v.9,1	917		yland
	land	-	10a. State 10b. County 10c. City, Town or Location				1	0d. tnside City Limits
	Mary Fled	ţ	MD Baltimore Dundalk					1 □ Yes 2 🔀 No
	ith the Marylan or 28a-f show	Director	10e. Street and Number 10f. Zip Code		10g. (Citizen of W	Vhat Coun	itry?
	death with the Maryland ms 23a or 28a-f show		1124 OLd North Point Road 21222		US	A		
	tems tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Oriently 13. Was Decedent of Hispanic Oriently 14. Was pecify Cuban, Mexican	igin? (Specify Ye.n, Puerto Rican, e	s or No-		e - Americ	
38	s afte	by Fe	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			Specify	White	e
/iS€ 5-0036	72 hours after natural', or ite	edt	15 Decedent's Education 16a Decedent's Usual Occupation		16b.	Kind of Bu		
> < 215	within 72 ene. than "na he Madii	plet	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired)	st of working				,
. N	giene giene artha	Completed	6th Homemaker			wn h		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Maralal Hygiens. Department of Health and Maralal Hygiens. Institutely, or items 23a or 28a-f show important; items 23a or 28a-f show any injury or other traumatic event, the Maralal Examiner must be notified at once.	Be		er's Name (First, nabelle			θ)	
25	should and Men marke umartic	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number				State, Zip	Code)
normas	alth ar 27 is r trau		George H. Thomas 111/son 922 Carsins Ru					
o√ ore,	as 1 a of He of He fitam r othe	3	20a. Method of Disposition 20b. Place of Disposition (Name of cemple), cemple of Cemp	Date		Location -		
E mi	Page ment tant: fi		'4 Donation 5 Other (Specify)	4/13/0	5 B	alti	more	MD
Balt	permit. Departn Imports any ink		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 300 Mace At	Connel	-			eofEssex 221
			23a. Part1. Enter the disease, or combilications that caused the death period enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	s cardiac or respira	atory arrest,			Approximate Interval Between
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	and and Il-transit	Examiner	that initiated events C.					
,00	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):					
	ate hys	Physician/Medical	d					
Box 68	leath certifica attending ph	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d Date	e of delive	any.
Bo	leath atten	cian	23b. Was decedent pregnant in the past 12 menths? 1 Yes 2 No			Mor		Day Year
P.O.	t ihe d by the achec	hysi	9 ☐ Unknown 9☐ Unknown					
Division of Vital Records, P	The law requires that the death certific are has been signed by the attending p page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1. 236	a. Did tobacco		ribute to th 3 □ Proba	ably 4 Unknown
cor	w requir	Completed		24:	a. Was an	24b. V	Nere autor	psy findings available
Be	ysician: The lavis certificate has director, page 2	шо		-	autopsy performed? Yes 2 1	? d	rior to con leath? Yes	npletion of cause of
ita	an: Tifica	a	25. Was case referred to medical 26. Place	e of Death (Check		40	103	20140
>	nysici nis ce direc	To B	examiner? 1 Yes 2 No	ursing Home 5[Residence	6 Sothe	er (Specify	bûspice
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sio	tendi Jeath. Tor: A the fu	cati	2 Accident Investigation M 1 Yes 2		-11 (611			10
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	To the Hospital or Attending Physician: within 2 thous state deals as the deals To the Funaral Director: After this certifies completely filled in by the funeral director, it	edicai C	29a. Certifier (Check only Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deal	nd place, and due ath occurred at th	to the cause	(s) and mai	nner as stand due to	ated. the cause(s)
	thin 2 thin 2 or tha omplet	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number		29d. D	Date signed	Month, I	Day, Year)
	F 3 F 8		M40854	4		4/11	200	
1	11		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			<u> </u>		
<u> </u>	1	- 1	David ARShip 30/ ST Paul Baltimore	mc.	515	25		
**	Sta Registr		31. Date filed (Month, Da), Year) 32 Alastra's Signature					

	1- State Unpend Item	State of Maryland 23a&27 per me (3 / Department 3842 et ilitoati	t of Health and Bath	l Mental Hyg	iene 005	1244
Physician /Medical	1. Decedent's Name (First, Middle, I Mark	,			2. Date of Dea Month April	Day Year	3. Time of Death
Examiner	4a. Facility Name (If not institution, g North Arundel I	Hospital	Gler	Town, or Location of De		4c. County of Death Anne Aru	nde1
Funeral Director	5. Social Security Number 6 282-72-7104 Usual Residence of Decedent	7. Age (In yrs. Ia 1 X M 2 □ F 31	Months	1 Year If Under 24 H Days Hours Mi			pplace (State or Fore untry) O
e or 28a-f show Le collified at	10a. State 10b. County		, Town or Location	Centreville			10d. Inside City Lim 1 ☐ Yes 2 🏋
23e or 28a-1 st ust be notified	10e. Street and Number 116 Frederick D	rive	10f. Zip	^{Code} 21617		10g. Citizen of What Col USA	untry?
Je E B	11. Marital Status 1 □ Never Married 2∑ Married	12. Was Decedent Ever in U.S Armed Forces?	3. Was Deced	lent of Hispanic Origin? ify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White	
To Should be littled within 72 hours after hand Mantal Hyglene. 7 is marked other then "neturel", or its traumatic event, the Mudical Ever that To Be Completed by Full To Be		Education grade completed) College (1-4or 5+)	life. DO NOT us	rk done during most of v se retired)	vorking	16b. Kind of Business/I	ndustry
ital Hygh of other event, I Be Cc	17. Father's Name (First, Middle, La		Project	18. Mother's N	lame (First, Middle,	Maiden Surname)	
th and Men T is marke traumatic	William Allen 19a. Informant's Name/Relationship William Allen T	(Type, Print)				essle r, City or Town, State, Z Park MD 21	
permit, rages I and a Department of Health Importent: If item 27 any injury or other tra	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	□ Removal from State	ace of Disposition (Name tery, crematory or of the Crematory of the Cremat	ne of ther place)	Date /9/05	20c. Location - City or Baltimore	Town, State
permit, P Departme Importen any injury once.	21. Signature of Funeral Service Lite	The second secon	22. Name an	d Address of Facility	of MD. T		
of physician and state the burial-transit state burial-transit state burial-transit sedical Examiner		b. Due to (or as a consequence) Due to (or as a consequence) C. Due to (or as a consequence)	ence of):				
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w requires man been signed b should be deta should by PI	Part II, Other significant condition	s contributing to death but not resu	Iting in the underlying ca	ause given in Part I.		obacco use contribute to ′es 2 □ No 3 □ Pro	11
cate has been so page 2 should					24a. Was a autop perfor 1 / Yes	sy prior to c	topsy findings avaitonal topsy findings avaitonal topsy and the completion of cause 2 \square No
Attending Physicien: The law requires that the beam certificate this certificate has been signed by the attending perfect this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as iffication: To Be Completed by Physician/Me	examiner? tx□xYes 2 □ No	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DO 28b. Time of Injury	26. Place of D Other: 4 Nursing 8c. Injury at Work? 1 Yes 2 No	Home 5□ Resid	ne) lence 6 Other (Speciow injury occurred	ify)
in Site			me, farm, street, factory	r, office	28f. Location (S City or Tow	Street and Number or Ru m, State)	ral Route Number,
n 24 hou n 24 hou he Funer pletely fill		Physician: To the best of my know aminer: On the basis of examinate and manner stated.	wledge, death occurred ion and/or investigation,	at the time, date and pla in my opinion, death or	courred at the time, of	date and place, and due	to the cause(s)
ed ple	29b. Signature and title of certifier		290	. License number	4	29d. Date signed (Month	Dev Voar)
vithin 24 hours a To the Funerel I Completely filled	-1	M. K.S.	us (OCME		April 9, 20	05

		For State Registrar	State of M	1arylan		artment <i>tificate</i>			and M		giene) Reg. No.	05	12444
		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	ith Day		3. Time of Death
Physici /Medic		John Francis	Tivvis, Jr.						Ì	April	6	Year 2005	8:10P M
Examin		4a. Facility Name (If not institution,	give street and number	r)		4b. City,	Town, or	Location o	f Death		4c. Cour	ty of Death	
		1425 Woodbridge	e Road					ville			Bal	ltimor	е
Funeral			6. Sex 7. A		last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day April	Year)	9. Birthp	place (State or Foreign htry)
Director		219-12-9517 Usual Residence of Decedent		81	Yrs.					April (30,192	3 Mary	'land
tand		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
Marylan -f show lied al	ţ	Maryland Balt:	imore		Cat	onsvi	11e						1 ☐ Yes 2 No
r 28a	Director	10e. Street and Number				10f. Zip					10g. Citizen o	f What Cour	ntry?
ours after death with the Maryla rel', or Itams 23a or 28a-1 shov		1425 Woodbridg	ge Road					21228	3		U.	S.A.	
deat	Funeral	11. Marital Status	12. Was Deceden Armed Forces		.S. 13. V	Vas Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. R	ace - Americ	
or its	F.	1 Never Married 2 Marrie				l ☐ Yes 2		Specify:	, 1 461101	rticari, etc.)	Spec	ack, White,	etc.
72 hours naturel',	d by	3 ☐ Widowed 4 ☒ Divorced	Year or Dates	: ww T	-		. 	орослу.				Whi	
nat	Completed	15. Decedent' (Specify only highest	s Education t grade completed)		16a. Deced	lent's Usua kind of won DO NOT us	k done di	urina most	of workii	ng	16b. Kind of	Business/In	dustry
withir sne. then	d L	Elementary/Secondary (0-12)	College (1-4or	r 5+)		e Man	,				Theati	rian1	
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland do they finan "naturel", or items 23s or 28s-f show event, the Madical Examinar must be notified.		17. Father's Name (First, Middle, L	.ast)		Stag	e man		18. Mothe	r's Name	(First, Middle,			
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturany injury or other traumatic event, the Madical once.	o Be	John F. Tivvis								t Utter		,	
shoul nd M mar	ř	19a. Informant's Name/Relationsh			19b. Mailin	g Address	(Street a			l Route Number		_	Code)
nd 2 lith a 27 is r trau		George Tivvis	(Son)		1425	Woodb	ridg	e Roa	ad C	Catonsvi	111e, N	D 212	28
s 1 a c f Head other		20a. Method of Disposition	_		Place of Dispo	sition (Nam	ne of	,	D	ate	20c. Location	- City or To	own, State
Page ent o nt: if		1 ☑ Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (Sp		8 _	eatlawr	,	nei piace		4-11	-2005	Marrio	ttsvil	lle, MD
mit.		21. Signature of Funeral Service L	icensee	-	1 22	. Name and	Address	s of Facility	¥	of Cato		т.	
Deparition on its permit of the parties of the part		Deman	Calro	sole	J 116	tzke 30 Edi	rune mond	raı H son A	iome Ivenu	or Caton	nsville sville	e, MD	21228
		23a. Part1. Enter the disease, or shock, or heart failure. List of	omplications that cause	ed the deat									Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Must	201	after	1-	MA	Late	la	NCFR			Onset and Death
/Medical		resulting in death)	a. Lue to (or a	s a conseq	uence of):	R		VV)	UT	isc ()		-	(monor)
Examiner		Sequentially list conditions	b										
De is	lnei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseq	uence of):								
and I-tran	Examlner	that initiated events resulting in death) Last	c Due to (or a	nasnos e a	uence of):	-							
be executed sician and burial-transit			540 10 (6) 4	3 & CO1136Q	derice or,								
the state	dlcal	11.	d										
leath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcom	e of pregna	ancy						234 L	ate of delive	101
atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Feta	Ideath 3□	Ectopic pre					1	fonth	Day Year
that the de led by the a detached (ysl	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown			,	,,						
that that ned b		Part II. Other significant condition	ns contributing to death	but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did tol	bacco use co	ntribute to th	e cause of death?
n sign	ed by									1 🗆 Y	es 2 No	3 Prob	ably 4 Unknown
tw require s been si should b	olete									24a. Was a		. Were auto	psy findings available
he lav	Completed									autops	med?	prior to cor death? 1 \(\text{Yes} \)	npletion of cause of
ysicien: The is certificate hidirector, page	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes :	20 No	Tores	2L NO
hysici this cer al direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpat	tient 2	ER/Outpatien	t 3 DO	Othe	p-		ne 5 Reside		ther (Specify	Haspiris
ng Ph ter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	jury ay Year)	28b. Time of Injury	28	Bc. Injury Work	at ?	2	28d. Describe ho	ow injury occi	rred	To part
aath. or: Af	atlo	2 Accident investig	ation			М		es 2 🗆 N	No				
r Att	Certification;	3 Suicide 6 Could no 4 Homicide determin	289. Place of It	njury - At ho etc. (Specif	ome, farm, stre	eet, factory,	, office		2	28f. Location (SI City or Town	treet and Nun n, State)	nber or Rura	l Route Number,
itel c													
the Hospitel or Attending Physicien: hin 24 hours after death. the Funerel Director; After this certifics apletely filled in by the funeral director.	ical	(Check only 2 Medical E	Physician: To the bes examiner On the basis	of examina	wledge, death tion and/or inv	occurred a restigation,	at the time in my opi	e, date and inion, deat	d place, a h occurre	and due to the ca ad at the time, d	ause(s) and r late and place	nanner as st , and due to	ated. the cause(s)
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Medical	29b. Signature and title of certifie	and manner s	stated.			License				9d. Date sign		
To To		X	11-	. 1		7	フつ	620	-/	man	1 141	11/00	
0,		30. Name and address of person w	Mo sompleted cause of	death (Item	23a\ /Tvpc	Print)	74	WY	/	HUYCH	7/	11/02	
\		2/ (110011	AS Duin				1401	Mills	nil	12/10	CAR	VEAR!	051860/
Sta	te	31. Date liled (Month, Day, Year)	32. Regis	trar's Signa	it de	vv I v	1	100	IV	9111/	۱۱۰ د	1 1 1-1	mp
Registr	-	4/1/05	APR 1 2 20	105	SO 0	J.	1900	West of					

1 - For State Registrer		State o	of Marylar		rtment e tificate			Mental Hy	giene	05	12445
1. Decedent's Na	ame (First, Middle, Las	st)						2. Date of De	ath		3. Time of Death
Physician /Medical S	hirley		М.	Tink	ler			APR	Day 7	200	5 650 PM
Examiner 4a. Facility Name MARIN	Off not institution, give JER HEAL	street and nu	mber) BELA1	R	4b. City, To	own, or Loc	AIR	1	4c. Cou	AR FO	ORD
Funeral 5. Social Security 044–12–	1	ex □M 2ဩF	7. Age (In yrs. 81	last birthday) _ Yrs.	If Under 1 Months D		Under 24 Hrs. ours Min.	(Month, Da	v. Year)	Col	nplace (State or Foreign untry) ecticut
Usual Residence	of Decedent		10c Cit	ty, Town or Loc	ation					1	
Or September 1		c 1	100. 01								10d. Inside City Limits 1 ☐ Yes 2X No
DILECTOR AND 10e. Street and I	_	ford			Aberde				10g. Citizen	of Mhat Co.	
A DI	1 Windemer	o Drive			101. ZIP 00	210	0.1		-		intry?
Light Harital Status Light Harital Status Light Harital Status Light Harital Status Light Harital Status Light Harital Status Light Harital Status		12. Was Dece	edent Ever in U	.S. 13. W	/as Deceden			pecify Yes or No o Rican, etc.)		S.A.	ican Indian.
~ 0 = _	arried 2 Married	Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2⊠No ve		Yes, specify ☐ Yes 2【X		lexican, Puerti pecify:	o Rican, etc.)	·	Black, White	ite
21215-0 ed within 72 ho solve in the natural last in the natural l	15. Decedent's Ed	lucation		16a. Deced	ent's Usual C	Occupation			16b. Kind o	f Business/I	
Elementary/Se	condary (0-12)	College (1	1-4or 5+)	life. D	O NOT use i	done dunn retired)	g most of won	king			
C Cor				Med	ical S						Hospital
e de le de la la la la la la la la la la la la la	e (First, Middle, Last)					18.		ne (First, Middle,		name)	
TO Deferments	hn Joseph l Name/Relationship (T		У	400 14-100			Phoe				
Transition of the state of the	, , ,		ahtar					ral Route Numbe			p Code)
20a. Method of D	t E. Briston	ow Dau	20b. F	_ 491 W:	ition (Name	of		Aberdeen Date	MD Z 20c. Locatio		own State
	2 Cremation 3 1		State	emetery, crem	atory or othe	er place)	Chm /	/13/05			
21. Signature of	Funeral Service Licens		Gal		Name and A			.1824 Re			
21. Signature of	phen ?	m Je	nkin.	E1:	ine Fu	nera]		Reiste			
23a. Part1. Ente shock, or h Immediae Caus disease or condi resulting in death	tion	a	aused the deat ach line.	h. Do not ente							Approximate Interval Between Onset and Death
Examiner	and distance	b	or as a conseq	uence or,							. 6.
Sequentially list if any, leading to cause. Enter Unit	immediate derlying	Due to (or as a conseq	uence of):							-
O SE CO MINITIALIBUINI	112	c. Due to	or as a conseq	uonno of).							
68760, and against a street of cause (Brans) for		d	or as a consequ	dence on).							
683.		· · · · · · · · · · · · · · · · · · ·									
ds, P.O. Box 6 ds, P.O. Box 6 ds, P.O. Box 6 ds, P.O. Box 6 ds, P.O. Box 6 ds, P.O. Box 6 ds, P.O. Box 6 ds, P.O. Box 6 life the death certification in the bast 1 ds, P.O. Box 6 life the death certification in the bast 1 ds, P.O. Box 6 by Physician/Me by Physician/Me by Physician/Me by Physician/Me can be seen as the control of the c	12 months?	1□Live b	come of pregna irth 2 Feta ant at time of do own	I death 3□E	Ectopic pregn Other <i>(specif</i>					Date of deliv Month	ery Day Year
Part II. Other sign	nificant conditions co	ontributing to de	eath but not res	ulting in the und	lerlying caus	se given in	Part I.	23e. Did to	bacco use co	ontribute to t	he cause of death?
Records, The law requires the law requires the law requires the law special page 2 should be completed by								1 □ Y	es 200 No	3 ☐ Prol	oably 4 Unknown
I Record The law requirements been a page 2 should								24a. Was a		o. Were auto	opsy findings available
Vital Recognition The law side of the law side of the law section, page 2 (sector, page 2) (sector, page 2) (sector, page 2) (sector, page 2) (sector, page 3)								autop. perfor	sy med? 2-2 No	prior to co death? 1 \(\subseteq \text{Yes}	impletion of cause of
X Ital X	erred to medical					26.	Place of Deat	h (Check only of		1 162	2 140
O Vita Of V	200			ER/Outpatient	3□ DOA	Other: 4	Nursing Ho	ome 5 Resid	ence 6 🗆 C	ther (Specif	(y)
After this After this Dr. Manner of De D	ath 5 ☐ Pending	28a. Date of (Monte	of Injury h, Day Year)	28b. Time of Injury	28c.	Injury at Work?		28d. Describe h	ow injury occ	urred	
Vision Vision	investigation 6 Could not be	00 00				1 Tes					
Division of De Division of Division of Division of Division of State of Aller of Aller of Homers of Division of Di	determined	buildir	of Injury - At ho ng, etc. <i>(Specif</i>)	me, tam, stree	et, factory, of	ffice		28f. Location (S City or Tow	treet and Nui n, State)	nber or Rura	al Route Number,
Division of Vita To the Hospital or Attending Physician: Within 24 hours after death. To the Hospital or Attending Physician: To the Funeral Director: After this certification by the funeral director, after this certification: To the Hospital	Certifying Phy	/sicien: To the iner: On the ba and mann	isis of examinal	wiedge, death dion and/or inve	occurred at the stigation, in a	he time, da my opinior	ate and place, n, death occur	and due to the c	ause(s) and i	manner as s	tated.
o in this in the second of the	d title of certifier				29c. Lie	icense nun	nber	2	9d. Date sign	ned (Month,	Day, Year)
	DIL M	1)			7	53V	652		h . 1	8 1	205-
30. Name and ad	dress of person who co	//	1 1 1			^	, ,	/	1 1911	2,00	100
Scott	- Haswe	// 2		, , , , ,	nul	131	1 Air	Mary	1 lunul	210	7/4
State 31. Date filed (Mo	APR 12		agistar's Signa		perle	,					

			1 - State of State of Registrar		artment of Health and tificate of Death	d Mental Hygien	6000 16770
	Dhyoisi	0.0	Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici /Medio		TURONE D. TUBM	AN			2005 2:04 PM
	Examir	ner	4a. Fecility Name (If not institution, give street and num	`	4b. City, Town, or Location of D		c. County of Death
			5. Social Security Number 6. Sex 7	Age (In yrs. last birthday)	If Under 1 Year If Under 24 I	RE (179	NA
Н	Funeral Director		213-52-3727 15M 20F	56 Yrs.		Ain. (Month, Day, Yea	r) 9. Birthplace (State or Foreign Country)
	D D		Usual Residence of Decedent	30		1CN 5, 19	71 100
	show d at	_	10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits
	8e-1:	octo	MD NA	BALT	MORE		1 Q∕Yes 2 No
	with t	Dir	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?
	eath	eral	3019 FERNDALE AVE. 11. Marital Status 12. Was Deced	ent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin	(Specify Ves or No	U.S.A.
(0	or Itan	Funeral Director	1 Never Married 2 Married 1 Yes 2	es?	Vas Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Po	uerto Rican, etc.)	Black, White, etc.
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28e-1 show deal Evarth or must be rediffed at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dat	es:	☐ Yes 2 1 Yoo Specify:		Specify: BLACK
2-(72 h natu	Completed	 Decedent's Education (Specify only highest grade completed) 	(Give	ent's Usual Occupation kind of work done during most of	working 16b.	Kind of Business/Industry
121	filed within Hygiene. other than "	mp	Elementary/Secondary (0-12) College (1-4	for 5+)	OO NOT use retired)	0	onstruction
	filed with Hygiene other the		17. Father's Name (First, Middle, Last)	CF	PENTER 18. Mother's	Name (First, Middle, Maide	- 17
Maryland	Mental I Mental I Markad o	To Be	Frank TUBMAN			GARET E	BURNS
ary	and N and N is mai		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or		or Town, State, Zip Code)
_	1 and 2 Health a am 27 is		MARGARET TUBHAN-MO		FERNDALE 1	LUE, BALLO	MD. 21207
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from SI	20b. Place of Dispos cemetery, crem	natory or other place)		Location - City or Town, State
Baltimore,	ment of tant: If it it.		`4 ☐ Donation 5 ☐ Other (Specify)	ARButus	Hen PARK 4	-15-05 E	BAlto. MD.
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or Itams 23a or 28e-1 show any injury or other traumatic event, Ira Medical Evertil or must be rediffed at once.		21. Signature of Funeral Service Licensee	22	Name and Address of Facility	Fun Syc P.F.	A
	202 4 4		23a. Part1. Enter the disease, or complications that can		6, 100x 0673	38 BAHE	MD, 21215 Approximate
			snock, or near failure. List only one cause on each	ch line.			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	r as a consequence of):	DEFILIFACY U	inns	
	Examiner		, A	1105			
	D #	ner		as a consequence of):			
V	ecute and -trans	Examin	that initiated events	as a consequence of):			
8760,	cate be executed physician and the burial-transit	aiE	5 5 5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	as a consequence of.			
	ficate g phys	edicai	d.				
Вох	that the death certificated by the attending produced for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome 23c. If yes, outcom	ome of pregnancy			23d. Date of delivery
В.	death	sicia	1 Yes 2 No	nt at time of death 5 🗌	Ectopic pregnancy Other (specify)		Month Day Year
P.0	that the led by the detachi	Phys	a □ Oukuowu				
s,	Se Le	bý	Part II. Other significant conditions contributing to dea	th but not resulting in the un	derlying cause given in Part I.		use contribute to the cause of death?
oro	w require been sig should b	eted				- -	2 Mo 3 ☐ Probably 4 ☐ Unknown
Records,	ne law has t ge 2 s	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
			OF Was approximately and incl			performed 1 ☐ Yes 2 ☐ N	o 1 Yes 2 No
Vital	Physicien: this certificaral director,	To Be	25. Was case referred to medical exammer? 1 Yes 2 No Hospital: 1 Inp	patient 2 ER/Outpatient	Other	Death (Check only one) g Home 5 Residence	C []Other (Openity)
			27. Manner of Death 28a. Date of		28c. Injury at Work?	28d. Describe how inju	
ior	ttendin death. tor: Afi the fur	atio	2 Accident investigation	Day (dai) Injury	M 1 Yes 2 No		
Division	I or Attendi after death. Director: A i in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of building	Injury · At home, farm, stre , etc. <i>(Specify)</i>	et, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, te)
	pital (29a, Certifier 1 Certifying Physician: To the b			1	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) 1 Certifying Physician: Fo the base and manne	is of examination and/or invi	estigation, in my opinion, death of	ccurred at the time, date an	id place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and Little of certifier		29c. License number	29d. Da	ate signed (Month, Day, Year)
•				1. D.	D0061529	A	1PRIL 9, 2005
	1		30. Name and addres son who completed cause	of death (Item 23a) (Type, F	Print)	W	
	Sta	10	31. Date filed (Month, Day, Year) 0 82 Bec	ristrar's Signature	Logisti 1	9008/17/46	
	Registr		APR 1 2 2005	istrar's Signature			

		1 - For State Registrar	State of Maryla		artment of H <i>rtificate of L</i>			lene 0 0 5	12447
Physic	ian	1. Decedent's Name (First, Middle, Last	^ ~				2. Date of Deat Month	th Day Year	3. Time of Death
/Medi	cal	CONCEPCION	C TORRE	<u> </u>	4h City Tourn or	Location of Death	MARCH	30, 2005 4c. County of De	10:49P.M
Exami	ner	4a. Facility Name (If not institution, give 3412 Sudlersvill			Laurel			Anne Ar	
Funeral		5. Social Security Number 6. Se	7. Age (In yr	s. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth	9. B	inthplace (State or Foreign Country) Puto Rico
Director		062-09-5925	DM 2XDF 97	Yrs.	Moriais Bays	Tiodis Iviiis	Dec. 8,	1907 Pue	rtó Rico
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town or Lo	ocation				10d. Inside City Limits
a-fsh	ctor	MD Anne Ar	undel I	aurel					1 ☐ Yes 21 No
or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What 0	Country?
death with the Maryland ms 23a or 28a-f show Finant ke rediffed at	eral	3412 Sudlersville	South 12. Was Decedent Ever in	110 12	20724	iconnio Origin? (Soc	acifu Vac ar No	USA 14. Race - Am	percan Indian
1036 ours after death with the Marylan rai', or Itams 23a or 28a-f show	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ௵No		Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	Black, Wh	
ours a	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		Puerto	Rican		Specify: WV	iite
d 21215-0036 filed within 72 hours after Hygiene. sther then "natural; or Ita ent, Ite Medical Emistra	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of works	ing	16b. Kind of Busines	s/Industry
within in them	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	/		Own Home	
Maryland 21 d 2 should be filed w th end Mental Hygier 7 is marked other it treumatic event, its	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Sumame)	
ylar	To	Miguel Colon		7			Rodrugi		<u> </u>
		19a. Informant's Name/Relationship (T Conchita Romero /						, City or Town, State, rel, Maryl	
re, M s 1 and 2 f Health Item 27 other tr		20a. Method of Disposition	20b.		sition (Name of matory or other place			20c. Location - City of	
O 0		1 Burial 2 □ Cremation 3 □ I 1 □ Donation 5 □ Other (Specify,	Tellioval Ilolli State		ge Mem. P	ark 4/2/2	005	Elkridge.	Maryland
Baltimore, permit. Pages 1 at Department of Hea Importent: if them any injury or othe		21. Signature of Funeral Service Licens			2. Name and Addres			NERAL HOME	, INC. /LAND 20707
		23a. Fart1. Enter the disease, or companies ock, or hear failure. List only of							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	0	STIVE	Hears	1 .	OF		Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conse				~ .		7 1/25
	e.	Sequentially list conditions,	b. CONES	TUE	CARD	10440	PATH	1	6925
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Colona	eu F	LOSAL	DIBENE	E		104RS
Geath certificate be executed death certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as a conse	equen e of):					
68760 tificate be e ig physiciar as the buri	edical		d						
BOX (leath certing attending)	an/M	23b. Was decedent pregnant	23c. If yes, outcome of preg 1□Live birth 2□Fe		Ectopic pregnancy			23d. Date of de	
at the dea by the at	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of 9□Unknown		Other (specify)			Month	Day Year
S, P. es that igned by be deta	by Ph	Part II. Other significant conditions co	_	sulting in the u	nderlying cause give	en in Part I.	23e. Did tot	pacco use contribute	to the cause of death?
Cords A require been sig should b	ted t	ATEIALHBRIC	eation &	ENAL	- taiw	E	1 □ Y€	es 2. Mo 3 ☐ F	robably 4 Unknown
Hecords, P.O The law requires that the tee has been signed by the bage 2 should be detached.	Completed		•				24a. Was a autops	y prior to	utopsy findings available completion of cause of
		05.11	 					2 No 1 □ Ye	s 2 No
Vital /sicien: T s certificat	o Be	25. Was case referred to medical examiner? 1 Yes 2 70	Hospital: 1 ☐ Inpatient 2	☐ER/Outpatier	nt 3 DOA Othe	26. Place of Death		e) ence 6 Other (Sp	ecify)
DIVISION OF I or Attending Phy after death. Director: After this i in by the funeral d	on: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day Year)	28b. Time of	f 28c. Injury Work		28d. Describe ho	w injury occurred	
SIO tendii Jeath. tor: A the fu	catle	2 Accident investigation 3 Suicide 6 Could not be	Bloom Bloom of John A			Yes 2 □ No	096 Lanting /64	and and Mumber of	2000 Carrie Monte
DIVI	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, rarm, str cify)	eet, factory, office		City or Towr	reet and Number or F n, State)	Rurai Houte Number,
DIVISION Of VITA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certificicompletely filled in by the funeral director,	edical (29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner a ate and place, and du	is stated. le to the cause(s)
To the veithin To the compl	Me	29b. Signature and title of certifier		-	29c. License		2	9d. Date signed (Mor	nth, Day, Year)
		Ladon	- WO		D 2	2755		4.1.	05
Ę		30. Name and address of person who c	JUMA 73:	50 VA	MEDISTER	J RO #2	الم مطا	NEEL MO	20707
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 2 20	32. Pogistrar's Sign	nature	parte				,

		State of Maryland / Department of Health and N	Mental Hy	•	12448
Physiciar /Medica		1. Decedent's Name (First, Middle, Last) Charlotte A. Tortorici	2. Date of De		3. Time of Death 7:53 PM
Examine	r	4a. Facility Name of not institution, give street and number 4b, City, Town, on Location of Death 4b, City, Town, on Location of Death 4b, City, Town, on Location of Death 4b, City, Town, on Location of Death 4b, City, Town, on Location of Death 4b, City, Town, on Location of Death 4b, City, Town, on Location of Death 4c, City,	MA	4c. County of Dea	th Molecular the place (State or Foreign
Funeral Director		200-28-7071 1□M 2⊠F 67 Yrs. Months Days Hours Min.	8. Date of Bir (Month, Da April	17, 1937 PA	ountry)
aryland aryland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
the M	runeral Director	MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	1 ☐ Yes 2 ☒ No puntry?
ath with	<u>a</u>	102 Crain Highway Apartment 897 21061		USA	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel; or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	by rune	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	pecify Yes or No Pican, etc.)		
15-0 15-0 in 72 ho " netu	be completed by	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of work in the completed of work done during most of work in the complete of the completed of the complete of the complet	king	16b. Kind of Business	Industry
d 212 d 212 filled with Hygiene. other than	E O	12 Homemaker		Homemaker	•
and d be fill the shall have been on the ceven of the shall have been on the ceven of the shall have been on the shall have been shall have be	0 00		e (First, Middle, SSETSMi	, Maiden Sumame) .th	
Marylar Stould be and Menta Is marked reumatic every		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rut</i>	ral Route Numb	er, City or Town, State,	Zip Code)
ore, Maryli ore, Maryli or Health and Mei item 27 is mark	3	Anthony Tortorici/ Son 8117 Mount Aventine R 20a. Method of Disposition April 20b. Place of Disposition (Name of commetery, crematory or other place) April	Date	vern, MD 21	
Pages nent of and riv or or or		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) Chesapeake Cremation 20	12,	Stevensvill	
Baltimo permit. Pages Department of Importent: If it any injury or once.		21. Signal Fundal Segric Licensee 22. Name and Address of Facility M01411 Singleton Funeral H	Iomo D		Ave. S.W.
		23a. Plant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death) Breat Caucal Breat			Onset and Death
/Medical Examiner		Due to (or as a consequence of):			
ped list	Illuer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or Injury.			
760, te be executed spician and te buriat-transit	Z	that initiated events c			
	_	IF FEMALE:			~
Records, P.O. Box 68760, The law requires that the death certificate be even the has been signed by the attending physician bage 2 should be detached for use as the burial programmed by Dhysician/Medical Expension	Sicially	23b. Was decedent pregnant in the past 12 movins? 1 Yes 2 ANO		23d. Date of de Month	ivery Day Year
hat the de ted by the detached		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
ords benefits and	nen	Congestive Heart Failure	10'	Yes 2 No 3 Pr	obably 4 UHKnown
Division of Vital Records, to Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be contribing that the funeral director.	illpie	,	24a. Was autop perfo	osy prior to death?	topsy findings available completion of cause of
10 11	ש	25. Was case referred to medical examiner?	1 ☐ Yes		2 No
on of Vita ling Physician: After this certific funeral director,	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho 27. Mannar of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 Other (Spe	cify)
Sion tending eath. or: Afte	Callor	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			
Division C tel or Attending P is after death. al Director: After ed in by the funers		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tov	Street and Number or Ru vn, State)	iral Route Number,
Division of Vita To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	alcal	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the red at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
To th within To th comp	SE	29b. Signature and title of certifier 29c. License number 7 19407		29d. Date signed (Mont	h, Day, Year)
10	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	4088171	46len
State		31. Date filed (Month, Day, Year) 32. Registrar's Signature	, _ (BUITIL
Registrar		APR 1 2 2005 Reserve & Jacks			
		ORIGINAL			

			For State Registrar	State of	Maryland / D	epartme Certifica	ent of H	lealth a Death	ınd M	entai Hy	giene		12449
	Dharist		1. Decedent's Name (First, Middl	e, Last)						2. Date of De	ath Da	v Year	3. Time of Death
	Physici /Medic		Frances O'B	riant Tur	ner							2005	18:05 M
	Examin		4a. Facility Name (If not institution	n, give street and numi	ber)	4b. Cit	y, Town, or	Location of			4c	. County of Death	
-		п	Upper Chesape	ake Medica	1 Center	В	el Ai	r				Harfor	E
	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2XX F	. Age (In yrs. last birth	Month	s Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birthp.	lece (State or Foreign try)
	Director		237-34-0923	10.141 2201	80 ,	rs.				Dec. 1	6, 1	924 Nortl	n Carolina
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						11	Od. Inside City Limits
N	Aarylar f show	ō	Maryland Harfo	~d	Bel	7 - 10							1 Yes 2 No
Q	the M 28e-f	Directo	10e. Street and Number	Lu	Del		Zip Code				10a. Cit	tizen of What Coun	trv?
8:05	23e or		209 Courtla	nd Place			2101	1		ļ	_	USA	
_	E 2	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S.	13. Was Dec			jin? (Spe	cify Yes or No Rican, etc.)		14. Race - Americ	
ဟ	b 2 €	Fur	1 Never Married 2 Mar	ied Armed Ford	. (XNo				Puerto F	Rican, etc.)		Black, White,	etc.
8	ral', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dat	es:	1 ∐ Yes	2 X No	Specify:				Specify: Wh	nite
5-0	72 hc	Completed		t's Education st grade completed)	16a. I	Decedent's Us (Give kind of t	sual Occupa	ation during most	of working	na .	16b. K	(ind of Business/Ind	lustry
7,2	within 72 ene. than "na	npi	Elementary/Secondary (0-12)	College (1-4	for 5+)	life. DO NOT	use retired)					
₩	filed w Hygier other ti		12	f4)	Adm	inistr	ative					nicipalit	<u> </u>
1/69/05 land 2121	2 should be filed within 72 hours and Mental Hygiene is marked other than "natural" aumatic event, the Medical Ex	Be	17. Father's Name (First, Middle, Thomas Leste)							(First, Middle			
7 5	should nd Men marke umatic	မ			401	14.77.	(2)	Lela			Dakl		0. (-)
4(69(05) Maryland 21215-0036	s 1 and 2 should be filed within 72 hr Heath and Mental Hygiene Item 27 is marked other than "natu other traumatic event, the Medical		19a. Informant's Name/Relations								-	or Town, State, Zip	Code)
			Robert B. Turne 20a. Method of Disposition	er / Husbar	20b. Place of cemetery	U9 Cour Disposition (A	rtland lame of	d Plac	ce, l	Bel Ain	Oc. Lo	D 21014 ocation - City or To	wn. State
کر	0 0		1 Burial /2 Cremation	3 Removal from Si	ate					10.05		,	
Baltimore,	permit. Pag Department Important: I any injury o		4 □ Donation 5 Other (S 21. Sign ture of Fit eral Service		ment Bel A						Be.	l Air, Ma	ryland
Ba	permit. Departrr Importa any inju		21. Signification of all service	U. Z		McCo	nas Fi	unera.	LHor	me, P.Z	Α	VE 010	
			23a. Part V Enter the disease, or	complications that car	used the death. Do no	ot enter the m						n, MD 210	Approximate
	5		shock, or heart failure. List Immediate Cause (Final	only one cause on ea	ch line.	or onto the m		g, 020/1 20 c		1	1		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Ce	elest v		La	CLE	car	e.1			
1000	Examiner			Due to (o	r as a consequ <i>e</i> nc <i>e o</i>	π):							
		ية	Sequentially list conditions, if any, leading to immediate cause. Enter Under ying Cause (Disease or injury	b. Due to (o	r as a consequence of	f):							
Par .	be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events	S .								1	
00 5	exec in and ial-tra	Еха	resulting in death) Last	Due to (o	r as a consequence of	f):	· · · · ·						
3439 18760,	icate be ex physician s the buria	dicai		d									
ω	certificate be executed nding physician and use as the burial-transit	edi	· · · · · · · · · · · · · · · · · · ·	p									
90 X	eath certific attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnancy th 2 Detail death	3 □Ectopic	oragoona.					23d. Date of delive	,
MR# O'P.O. Bo	requires that the death een signed by the atter nould be detached for u	icia	in the past 12 months?	4□Pregna	nt at time of death	5 ☐ Other (Month	Day Year
MK华 P.O.	that the de ed by the detached	hys	9 Unknown	9□ Unknov	vn					1 00 -			
S, F	res tha igned be de	oy P	Part II. Other significant conditi	ons contributing to dea	th but not resulting in	the underlying	g cause give	en in Part I.		23e. Did t	obacco i	use contribute to th	e cause of death?
	w require been sig should b	ed								1 🗆	Yes 2	□ No 3 □ Proba	ably 4 Sunknown
TANCES of Vital Record	aw is b	Completed								24a. Was		24b. Were autop	psy findings available inpletion of cause of
Frances on of Vital Re	0 5 0	E	-							perfo	rmed? 2 ☐ No	death?	2 No
ital	i cian: Th certificate rector, pag	Be C	25. Was case referred to medica					26. Place	of Death	(Check only o	/		
£ 33.	di is	은	examiner? 1 ☐ Yes 2 ☐ No	Hospital: \ In	patient 2 ER/Outp	patient 3 🗆 t	DOA Othe	er: 4 □ Nur	sing Hon	ne 5 ☐ Resi	denc <i>e</i>	6 ☐ Other (Specify)
4 =	ding Phys After this funeral di	ü	27. Manner of Death Natural 5 Pendir	28a. Date of (Month,	Injury 28b. Ti Day Year) In	ime of jury	28c. Injury Work	/ at </td <td>2</td> <td>8d. Describe</td> <td>how inju</td> <td>ry occurred</td> <td></td>	2	8d. Describe	how inju	ry occurred	
ر . اق	Attending r death. ector: Afte by the fune	catio	2 Accident investi	gation		М	101	Yes 2□N	10				
rner, f	or Att ifter d Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 289. Place o	f Injury - At home, fari g, etc. <i>(Specify)</i>	m, street, facto	ory, office		2	8f. Location (City or To	Street an wn, State	nd Number or Rura. 9)	Route Number,
orner, Division	spital or Attending Phous after death. evra Director: After th			<u> </u>									
F	Hospital Hospital Funeral tely filled	edicai	(Check only 2 Medical	ig Physician: To the b Examiner: On the bas	is of examination and	death occurre Vor investigation	ed at the time on, in my of	ae, date and ofnion, death	i place, a h <i>o</i> ccurre	nd due to the id at the time,	cause(s) date and) and manner as sta d place, and due to	ated. the cause(s)
	the the the	Med	one) 29b. Signature and title of certifie	and manne	n stateu.	9	29c. License	e number			29d. Da	te signed (Month, I	Day, Year)
	To To			< >					4		-1		
	OX			y 5 C	of death (here so-)	Tuna Pri-th	3 3	55.))		176	1/10,	200
	10		30. Name and address of person	S 141 1 6	15 101 /	marg	h a /						
	Sta	ate.	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature	needle !	14.6						
	Registr	•	APR 12	32. Re	w so so								

			1 - For Amend Items Registrer	23a, 24,2	aryland / I 5,26,27,	Depa 29a Cen	rtment of Ho fificate of E	ealth and l er Dr., eath	Mental Hy 3 842,0 4	giene 12/0 Reg. No	534h 5	12450
	Physici	an	Decedent's Name (First, Middle, La						2. Date of De Month			3. Time of Death
	/Medic	al	4a Fecility Name (If not institution, give	e street and number			4b. City, Town, or	Location of Death	04	00	County of Death	0038 AM
	Examin		Eastern Correct	Veck Fa		ion	Westove		21890		20MECSE	+
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	ge (In yrs. last bii		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ay, Yeer)	9. Birtho	place (State or Foreign
	Director		Usual Residence of Decedent	M 2□F	63	Yrs.			Mara	0,19	42 Mary	Lánd
	yland iow		10a. State 10b. County		10c. City, Tow	n or Loc	ation				1	Od. Inside City Limits
	a-fsh	ctor	MD Somers	et	W	esto	ver					1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number	1 70 1			10f. Zip Code	1.000			izen of What Cour	ntry?
	eath v		30420 Revells Ne	CK KOad 12. Was Decedent	Ever in II S	13 14	1	1890	necify Ves or N		SA 14. Race - Americ	can Indian
920	72 hours after death with the Maryland Instural', or Items 23a or 28s-f show Iteal Examinat he molified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces 1 ZYes 2 If Yes, Give Year or Dates:	No		/as Decedent of His Yes, specify Cubar □ Yes 2☑ No	Specify:	o Rican, etc.)		Black, White, Specify: bla	etc.
2-0	72 hours "natural", dical Ex	ted	15. Decedent's E (Specify only highest gr	ducation	16a	. Decede	ent's Usual Occupa ind of work done di	tion uring most of wor	unk	16b. K	ind of Business/In	dustry unk
21215-0036	d within jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	O NOT use retired)	ang most of wor	······································			
nd	ild be filed lental Hygir ked other ilc event, L	Be	17. Father's Name (First, Middle, Last James E. Te					18. Mother's Nan	ne (First, Middle	, Maiden	Sumame)	unk
Maryland	2 2 2 2	ဥ	19a. Informant's Name/Relationship		101	Mailing	Address (Street a	nd Number or Ru	ral Boute Numb	or City	r Tourn State Zin	Code
	Tra fr	19	Caroline Carey/f				Tioga Pk				1215	, 5555)
Baltimore,	of H of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special	Removal from State	cemete	f Dispos	ition (Name of atory or other place)	Date	20c. Lo	ocation - City or To	own, State
Balti	permit. Pag Department Importent: any injury o		21. Signatul of Euneral Sarv Lice Ronal I		e cor	St Ba	Name and Address ate Anato ltimore,	of Facility Omy Boar MD 2120	d 655 W	. Ba	ltimore S	Street
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that cause one cause on each i	d the death. Do					rrest,		Approximate Interval Between
E	Physician	(ii	Immediate Cause (Final disease or condition	a Coro	rary	H_1	rtery	Disec	ise		4	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	J					
		er	Sequentially list conditions,	b. Due to (or as	a consequence	of					10	
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
90,	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or as	a consequence	of):						
68760,	ificate be executed g physician and as the burial-transit	edicai		_ d								
Box 6	eath certifi attending I for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		• •					23d. Date of delive	ery
.O. B.	The law requires that the death cert lie has been signed by the attending page 2 should be detached for use	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death t time of death		Ectopic pregnancy Other <i>(specify)</i>				Month	Day Year
Δ.	that the par	by Ph	Part II. Other significent conditions	contributing to death t	out not resulting i	n the und	derlying cause give	n in Part I.	23e. Did	obacco i	use contribute to th	ne cause of death?
rds	w requires been sign should be								1 🗆	Yes 2	□No 3 □ Prob	abiy 4 Kunknown
of Vital Records,	law re as bec 2 sho	Completed							24a. Was		24b. Were auto	psy findings available impletion of cause of
E E		Соп							perfo 1 ☐ Yes	2X No	death?	
Vita	Physiclan: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	ent 2□ER/Ou		Othor	26. Place of Dea	th (Check only one 5 Resi			. T., 64
	ding After fune		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		Time of Injury	28c. Injury Work		28d. Describe		**) Infimary
Division	spitel or Attending ours after death. leral Director: After filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of in	jury - At home, fa tc. (Specify)	arm, stre	et, factory, office		28f. Location (City or To		d Number or Rura)	il Route Number,
	Hos Per Hos	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medicel Exam	nysician: To the best miner: On the basis of and manner st	of examination an	e, death nd/or inve	occurred at the time estigation, in my opi	e, date and place nion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as st place, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1			29c. License			29d. Da	te signed (Month,	Dey, Year)
			Dr. Enio	la			D00508	26		Apri	1 11,200	5
			30. Name and address of person who					30420	Revel1			
		10	Razaak Eniola 31. Date filed (Month, Day, Year)	,M.D., Eas	rario Signaturo			nstituti	on, We	stov	er,MD 21	890
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 20	105 Karen	ar s Signature	108	ess.					

			State of Maryland / Department of Health and 1- State Registrar Certificate of Death	Mental Hygie	•
	Physic		1. Decedent's Name (First, Middle, Last) MARY TINIXLER	2. Date of Death	Day Year 3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER RANDALLSTON	th	4c. County of Death BALTIMORE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days House Min	8. Date of Birth	9 Birthplace (State or Foreign
	Director		Usual Residence of Decedent	08613	1920 MARYLAND
	the Marylan r 28a-f show	ō	10a. State 10b. County 10c. City, Town or Location MD CARROLL ELdenshung		10d. Inside City Limits 1 XYes 2 □ No
	or 28a-	Funeral Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Country?
	death w	eral	2014 B RUDY SCRRCL DRIVE 21784 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5	Specify Yes or No-	USA 14. Race - American Indian,
5-0036	hours after death with the Maryland uret', or Items 23a or 28a-f show at Examinar must be notified at	by	If Yes, Give 1 ☐ Yes 2 No Specify:	to Rican, etc.)	Black, White, etc. Specify: White
15-6	"ned"	Completed	15. Decedent's Education (Specify only highest grade completed) Elements (Specify only highest grade completed) Elements (Specify only highest grade) (Sive kind of work done during most of wo life. DO NOT use retired)	rking 16t	b. Kind of Business/Industry
2121	filed within I Hygiene. other then "	Com	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker		own Home
land	ld be fill ental H ked oth	To Be	17. Father's Name (First, Middle, Last) BURLEY ELSE ROAD 18. Mother's Nam MARY	me (First, Middle, Mai Hilda E	. ^
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 Is marked other then other treumstic event, the M	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Relationship)	ural Route Number, C	ity or Town, State, Zip Code)
	s 1 and of Health item 27 other to		20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place)		c. Location - City or Town, State
Baltimore,	Page ento nt: If		· 4 Donation 5 Other (Specify) MT GILEAU CEMETERY APP.	2 2005 WE	DODENSBURG, MO
Ball	permit. Pag Department Importent: eny injury conce.		21. Signature of Funeral, Service Licensee 22. Name and Address of Facility 23. Signature of Funeral Service Licensee		•
	*		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiar shock, or heart failure. List only one cause on each line.	or respiratory arrest,	LOCAL BURG MO 21784 Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a		Onset and Death
ľ	Examiner		Sequentially list conditions b. ACUTE PANCREATITI	3	
	uted d ansit	Examiner	facy leading Limmediat. Cause. Enter Underlying Cause (Disease or injury that initiated events C.		
8760,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):		
9	tificate ng phys as the	ledical	d		
P.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
	res that the de signed by the a l be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
cord	w require been si should b	leted	DIABETES MELLITUS.	1 ☐ Yes	
of Vital Records,	iicien: The lav certificate has rector, page 2 :	e Completed		autopsy performed 1 Yes 2 X	
of Vi	Physicie this cert al direct	ToB	examiner? 1 Yes 2 Vo	th <i>(Check only one)</i> ome 5 ☐ Residence	e 6 □Other (Specify)
ono	nding P th. : After t s funera	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work? 1 Yes 2 No	28d. Describe how in	njury occurred
Division	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St.	t and Number or Rural Route Number, late)
	a Hospit 24 hour b Funere etely fille	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the cause rred at the time, date a	s(s) and manner as stated. and place, and due to the cause(s)
)		Me	29b. Signature and The accentifier A PHYSICIAN 29c. License number D42723	29d. [Date signed (Month, Day, Year)
	13		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHWESTAVVERALALLI M HARISH 5401 0 LD	Course	PORP MD 21133
	Sta Registr		31. Date filed (MoMippay, Mear) 2005 32 Registrar's Signature		

			For State Registrar		State of N	/larylan		artment of H tificate of L		Mental Hy	giene Reg. No	(UU)	12452	
	Physicia /Medic		Decedent's Name (First, Mic MICHAEL	dle, Last)				TSE	YTLIN	2. Date of De Month APRIL	ath Day	y 2005	3. Time of Death 4:55 P M	
	Examin		4a. Facility Name (If not institut 1882 AUTUMN F	ROST	LANE		4	4b. City, Town, or BALTIMO If Under 1 Year				BALTIMOR	RE	
	uneral irector		5. Social Security Number 217-92-1834 Usuel Residence of Decedent	6. Sex	M 2□F	Age (In yrs. I	last birthday) Yrs.	Months Days	Hours Min		¹⁹ , 194	.4 9. Birth	nplace (State or Foreign untry) UKRAINE	
Maryland	fact at	tor	10a. State 10b. Cour	ty LTIMO)RF	10c. City	y, Town or Lo	cation I MORE					10d. Inside City Limits 1 ☐ Yes 2 🔀 No	
h with the	3a or 28a at be notif	ai Director	10e. Street and Number 1882 AUTUMN				21,12	10f. Zip Code	21209		10g. Cit	tizen of What Cou	untry? USA	
d Z 1 Z 1 3-0030 filed within 72 hours after deeth with the Maryland	r neelin and weelin any system in yet en in them \$2a or \$8a-f show filen 27 is anxied other than "natural", or lieums or neatled other treumstic event, the Modical Examiliar result by notified at	by Funerai	11. Marital Status 1 □ Never Married 2 💢 M 3 □ Widowed 4 □ Divorce	arried	2. Was Decede Armed Force 1 Pes 25 If Yes, Give Year or Date:	s? (] No		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🙀 No	spanic Origin? (n, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)	>-	14. Race - American Indian, Black, White, etc. Specify: WHITE		
within 72 ho	than "natur re Medical I	Completed	15. Deced (Specify only hig Elementary/Secondary (0-12	nest grade	ation completed) College (1-4d	or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired DRIVER	lurina most of w	rorking		(ind of Business/1	ndustry	
yland 212 tould be filed within	other vent,	Be Co	17. Father's Name (First, Midd	e, Last)						ame (First, Middle	, Maiden	Sumame)		
should b	narked natice	To	BORIS	ashir Com	o Grath		TSEY	TLIN	EVA	Pum I Pouto Numb	or City	or Town State 7	ELSON (in Code)	
- N	neeiin and tem 27 is ma ther treums		19a. Informant's Name/Relation		-			AUTUMN F						
Daltillore,	Department of neelin Importent; If Item 27 I eny injury or other tra		20a. Method of Disposition 1 X Burial 2 ☐ Crematio 1 4 ☐ Donation 5 ☐ Other		emoval from Sta	to C	emetery, crer TIMORE	sition (Name of matory or other place HEBREW (EM. 04/		F		TOWN, MD	
permit.	Import eny inj		21. Signature of Funeral Servi	e Liceose	θ		8	2. Name and Addres	SS OF FACILITY S	SOL LEVIN N ROAD -	ISON PIKE	& BROS. ESVILLE,	, INC. MD 21208	
//\	ysician Medical aminer	e.	23a. Part ! Enter the dispase, shork, or heart silver. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	or complicing the second of th	Due to (or	n line.	uence of):	er the mode of dyin			irrest,		Approximate Interval Between Obset and Death	
icate be executed	attending physician and for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(Due to (or	as a conseq	uence of):							
UNISION OF VITAIN DECOLUS, T.O. BOX OF TO THE HOSPITAL HE GESTION.	been signed by the attending pl should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	3c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknowr	2 □ Feta at time of d	Ideath 3	Ectopic pregnancy				23d. Date of deli Month	very Day Year	
law requires that	in signed by	by	Part II. Other significant cond	itions con	tributing to deat	n but not res	ulting in the u	nderlying cause give	en in Part I.			مس	the cause of death?	
The law re	has e 2	Completed								24a. Was auto peri 1 \(\text{Yes}		prior to death?	topsy findings available completion of cause of	
sicien:	certific	o Be	25. Was case referred to med examiner?		ospital:	ationt 2	ER/Outpatier	nt 3 DOA Oth	00	eath <i>(Check only</i> Home 5 X Res		6 □Other (Spec	outv)	
VISION OF	within 24 nou's after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	on; T	27. Manner of Death	ding stigation	28a. Date of I		28b. Time o Injury	f 28c. Injur Wor	y at	28d. Describe			ney)	
tal or Atte	rs affer de el Directo ed in by th	Certificati		ld not be ermined		Injury - At he etc. (Specif		reet, factory, office		28f. Location City or To			ral Route Number,	
the Hospi	the Funer	ledicai	(Check only 2 Medic	al Examir	nician: To the be ner: On the basis and manner	s of examina stated.	ition and/or in	h occurred at the tin vestigation, in my o	pinion, death oc	curred at the time	date an	d place, and due	to the cause(s)	
To	Nut Con Con	2	29b. Signature and title of cert	Ver	Id	No 10		Print)	753Z		Ajo	ate signed (Monti	2005	
5			30. Name and address of pers	on who co	mpleted cause of	of death (Item	Scutti	Grant	st., E	3elt, mor	0,1	48 217	101	
	Sta Registi		31. Date filed (Month, Day, Ye APR 1 2 20		32. Reg	istrar's Signa	ature							

Lornell A. Wilkins Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unknown 05-2305 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer 05 - 2305Certificate of Death Reg. No. DOS 1 Decedent's Name /First Middle Last 2. Date of Death 3. Time of Death Month Day 2005 **Physician** April 1 1542 p /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2400 Greenmount Avenue Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday)
Yrs. 8 Date of Birth (Month, Day, 5 Social Security Number Birthplace (State or Foreign
 Country) 6. Sex **Funeral** M 2□F Usual Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County item 27 is marked other than "neturel", or Items 23a or 28e-1 show other treumetic event, the Modical Executive coust be notified at 1 XYes 2 ☐ No Director more10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐ Yes 2 No Yes, Give 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working ife. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than College (1-4or 5+) Mother's Name (First, Middle, Maiden Sumame) (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tre 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ю. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mutple gunshot

Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner burial-transit Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year Po in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No. 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1 Xas 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 5 Residence 6 Nother (Specify) at scene 0 1 XYes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home this 28b. Time of 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: of or Attending Patter death.

I Director: After approniury 5 Pending investigation 1 Natural Subject Shot April ,2005 1 Yes 2 XNo 3:35 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2400 block Civeln vig. wt 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide vemce the Hospitel o 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier othe Hu within 2/ To th 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME April 2, 2005 MD Jano have 30. Name and address of persolution completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 1.D Gruce nbeva Tasha 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Req. No. 1. Decedent's Name_(First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year HARLES **Physician** 2:00 AM NATHANIEL 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner FRANKLIN SQUARE HOSPITAL CENTER BALTIMORE ROSEDALE 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours NORTH CAROLINA 239.74.0001 Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at BATIMORE 1 Yes 2 No Be Completed by Funeral Director MD10f. Zip Code 10g Citizen of What Country? 10e. Street and Number Items 23a or U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 LYes 2 □ No 1 Never Married ŏ 1 Yes 2 No land 21215-0036 If Yes, Give Year or Dates: 3 Widowed 4 Divorced neturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than * TRANSPORTATION College (1-4or 5+) TRUCK DRIVER 18. Mother's Name (First, Middle, Maiden Surname)

MARGARET MCK 17. Father's Name (First, Middle, Last) Baltimore, Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BATIMORE, MD 21212 MED FORD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 13.05 DWINGS MILLS, MARYLAND any injury or conce. 1 Burial 2 Cremation 3 Removal from State GARKISON FOREST ' 4 ☐ Donation 5 ☐ Other (Specify) ANGHIN C. GREENE TWERK HANE 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Jaugh BALTIMORE, NO or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) PANCREATIC CANCER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 2 No 1 Tyes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Director; After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide To the Hospitel within 24 hours a To the Funerel E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of sertifier Mp, d 0061402 05 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DRIVE BALTIMORE MD 21237 Dr. DAWEI Registrar's Signature 31. Date filed (Month, Day, Year) 32 State APR 1 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) B 2005 **Physician** APRIL SR. EDWARD Ρ. WEIGMAN 4:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL CO. GLEN BURNIE MARINER HEALTH OF GLEN BURNIE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex. **Funeral** 215-30-6506 70 Maryland **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 27 is marked other than "natural", or Items 23e or 28e-f show traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 862 Turf Valley Drive 21122 U.S.A. Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Bill Poster Sign Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pau1 Florence Riggs Weigman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) L. 862 Turf Valley Drive, Pasadena, Maryland 21122 Weigman (Wife) Jane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of I-Important: If Ite any injury or ot 1 Burial 2 Cremation 3 Removal from State New Cathedral Cem. 04-12-05 ` 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Mary 21. Signature of Funeral Service to need Maryland 21122 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final 6190 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy ó Month Day Year 4 Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached! 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2016 m 3 ☐ Probably 4 ☐ Inknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of eause of death? 24a, Was an autopsy performed? 2 No 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nutsing Tiome 1 🗌 Yes 2 □.No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director; A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 leted cause of death (Item 23a) (Type, Print) 30. Name and address of person URY Dac 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 2 2005 Registrar

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H <i>rtificate of L</i>			ene 005	12456
			Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		Bertha May	Warfield	1			April	8 2005	4:30 A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ith
		•	7952 Oak Road			Pa	sadena		Anne A	rundel
	Funeral		5. Social Security Number 6. Se		e (In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bi	rthplace (State or Foreign ountry)
	Director		220–18–5128]M 208F	93 Yrs.	Monais Days	riours Min.	June 21		ryland
	D .		Usual Residence of Decedent							Table to as its a
	how	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	e Ma	5	Maryland Anne Aru	ıdel	Pasadena					
	or 24	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	23e		7952 Oak Road				21122		USA	
	ems.	Ine	11. Marital Status	12. Was Decedent 8 Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	or it	by Funeral	1 Never Married 2 Married	1 ☐ Yes 2 ☐ €	10	1 ☐ Yes 2 No	Specify:		Specify: V	Vhite
8	within 72 hours after deeth with the Maryland ene. then 'naturef', or items 23a or 28a-f ehow the Mudical Exercities mast be notilised at	q p	3 Widowed 4 □ Divorced	Year or Dates:	160 Dags	dent's Usual Occupa	ation	1	6b. Kind of Business	Maduata
7	"nat	Completed	15. Decedent's Edi (Specify only highest grad		(Give	kind of work done of DO NOT use retired	during most of worki	ing	OD. KING OF BUSINESS	y moustry
42	withii ane. then	E G	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Homemaker	,		Own Home	
22	Hygie ther nt,		17. Father's Name (First, Middle, Last)			Tomemaker	18. Mother's Name	(First, Middle, M		
an	d be	Be C	Taba U Casasal				Ella (Goldstra	t.T	
Maryland 21215-0036	hould Me mark	10	John W. Seward 19a. Informant's Name/Relationship (T	vpe. Print)	19b. Mail	ng Address (Street a			W City or Town, State,	Zip Code)
≅	d 2 s th an th an treu		Delores Zeman (da			Oak Road			-	
a,	1 and Heal		20a. Method of Disposition	igitei)	20b. Place of Disp	osition (Name of			Oc. Location - City o	r Town, State
2	nt of nt of t: # it		1 Burial 2 □ Cremation 3 □			matory`or other plac		OF D	1.4.4	M
altimore,	it. Portme		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 		The same of the sa	 Cemeter Name and Address 		-UO D	altimore,	Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mentat Hygiene. Importents if item 27 is marked other then "naturaf", or items 23a or 28a-f show any injury or other treumatic event, the Mudical Examination at any injury or other treumatic event, the Mudical Examination at any once.	1		Kevin E.	. Ecker	ՈգԸս <u>Լ</u> 1y-Рբ	olyniak Fı	uperal He	ome P.A. re, Maryla	and 21220
			23a. Part1. Enter the disease, or comp	lications that caused	the death. Do not en					Approximate
			shock, or heart failure. List only of Immediate Cause (Final	ne cause onyeach lin	10.	0 1	- 0			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Chre	rue !	and To	Julia			6 Week
	Examiner			Due to or as	a consequence of):	win				t. P. a. a
		_	Sequentially list conditions,	b. Due to (or as a	a consequence of):					gran
	ted rsit	Examiner	If any leading to immediate cause. Enter Underlying Cause (Disease or injury							
	and and al-trar	xar	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
8760,	cate be executed physicien and the burial-transit	aiE		_						
387	phys phys s the	dicai		d		·				
9 X	that the death certificated by the attending posterior as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of de	elivery
Вох	atter for u	clar	in the past 12 months?	1□Live birth 4□Pregnant at		⊒Ectopic pregnancy ⊒ Other (s <i>pecify</i>)	'		Month	Day Year
o.	the d	ysi	1 ☐ Yes 2. ♠No 9 ☐ Unknown	9☐ Unknown						
<u>Д</u>	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	4 V	Part II. Other significant conditions co	intributing to death bi	ut not resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds	urres s sign	d by	ATTO	IM FIB	RILLATIO	7		1 🗆 Ye	s 2 🗆 No 3 🗆 F	robably 4 Unknown
200	w require been si should t	iete	DEN	MENTA				24a. Was an	24b. Were a	utopsy findings available
Be	The law sete has page 2 s	Completed						autopsy	prior to death?	completion of cause of
<u></u>	m		OF 1Man ages referred to medical				00 51 (5-4)		No 1 □ Ye	s 2XNo
₹	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:		at all DOA Other	er: Death			
ō	Physral di	\vdash	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatie		III 3 LI DOA	4 Nuising no	28d. Describe hor	nce 6 ⊡Other <i>(Sp</i> winjury occurred	ecity)
o	ding P h. After funera	tion	1 Matural 5 ☐ Pending	(Month, Da)	y Year) Injury	Worl	k? Yes 2 □ No			
Si	f or Attending after death. Director: After I in by the fune	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Init	ury - At home, farm, s		-	28f. Location (Str	eet and Number or F	Rural Route Number,
Division of Vital Records,	after Direction by	Certification;	4 ☐ Homicide determined	building, etc	c. (Specify)	,,,		City or Town,	State)	
	To the Hospitel or Attending Phyeicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1. Certifying Phy	/sician: To the best	of my knowledge, dea	th occurred at the tin	ne, date and place.	and due to the ca	use(s) and manner a	is stated.
	24 h 24 h Fur etely	edicai	(Check only 2 Medical Examone)	iner: On the basis of and manner sta	f examination and/or i	nvestigation, in my o	pinion, death occurr	red at the time, da	te and place, and du	e to the cause(s)
	othi othi ompl	₩	29b. Signature and title of certifier	-01		29c. License	e number	29	d. Date signed (Mor	ith, Day, Year)
)	F S F O		Wichal I	desenta	un	D	N 438		04.08.	2005
	A		30. Name and address of person who d	ompleted cause of d	leath (Item_23a) (Tyne	Print)	<u> </u>			
	(')		MICHAEL I PER		44 (DEFE	WSE HE	HWAY AN	MAPULI	MD 2140	11-8915
	Sta	te	31. Date filed (Month, Day, Year)	•	ar's Signature					
	Registi		APR 1 2 2005	Realing	I Ann	W				

DHMH 17 Rev 1/2001

State

Registrar

M.D

32. Registrar's Signature

Coveen be ver

31. Date filed (Month, Day, Year)

APR 1 2 2005

Baltimore, Maryland 21201

		State of Maryland / Department of Health and N 1- Stete Registrar Certificate of Death			12458
		Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
Physi		UTITAM DODERT HARD ID	Month	Day Year	М
/Med	dical	WILLTAM ROBERT WARD, JR. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	April 8	4c. County of Death	11:24 P
		GILCHRIST CENTER Towson		Baltimor	e County
Funera	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birth	place (State or Foreign intry)
Directo	or	214-12-8660 X Yrs. 84 Yrs.	June 11		ryland
and * -		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		,	10d. Inside City Limits
Maryl t sho	5	Maryland Baltimore County Rodgers Forge			1 Yes 2 No
the t	Director	10s. Street and Number 10f. Zip Code	10	Og. Citizen of What Cou	
3 or	Ō	133 Glen Argyle Road 21212		USA	
death with the Maryland ms 23a or 28e-t show	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
or Ite		Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 □ Never Married 2 ☑ Married I ☑ Yes 2 □ No 1 □ Yes 2 ☑ No Specify:	Hican, etc.)	Black, White	
ours Lear,	d by	3 ☐ Widowed 4 ☐ Divorced			hite
72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	ing	16b. Kind of Business/l	ndustry
T2 Mithih Then Then	E D	Elementary/Secondary (0-12) College (1-4or 5+)		14 m	• •
Hygie ther int,	e Co	12th Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, N	<u>Mass Trans</u>	31.t
Maryland 21215-0036 at 2 should be filed within 72 hours alt the and Mental Hygiene. 27 Is marked other then "natural", or treumetic event, the Medical Exam	20				
shoul mark	2	William Robert Ward, Sr. Mathi 19a, Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rur		Gluth City or Town, State, Zi	p Code)
Ma nd 2 aith ai		Dorothy M. Ward (Wife) 133 Glen Argyle Road,	Baltimo	re MD 212	2
S 1 a ltem ltem othe		20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or T	
MO Page Bent c		1 Special 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Dillaney Valley Mem Grans 4	/12/2005	Timonium	Maryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Important: It frem 27 is marked other then "natural", or Hems 23a or 28e-1 show any injury or other treumetic event, the Madeal Examination in the Indifficed at	SUCE.	21. Signature of Funeral S vio Libertone 22. Name and Address of Facility			
a a a a a	8	Martin D. Lawson Mitchell-Wiedefeld		•	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	est, Maryland	Interval Between
Physicia	n	Immediate Cause (Final disease or condition a. Metastatic non-small consulting in death)	ell L.	19 Conces	Onset and Death
/Medica		resulting in death) Due to (or as a consequence of):			
Examine		Sequentially list conditions, b.			
- T - T - T - T - T - T - T - T - T - T	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause, (Disease or injury			
and and all-tran	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
332L safeto, cate be executed physician and the burial-transit.	E III				
687 ficate	edicai	0.			
Box nath certification of the ruse is for use is	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deliv	егу
	Physician/Me	in the past 12 months? 1 Types 2 Tho 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
cords, P.O. vequires that the doben signed by the should be detached	hys	9 Unknown		1	
ords, P.O requires that the een signed by the nould be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	
Cord w requir		chronic obstructive lung disease	Ye	s 2 No 3 Pro	bably 4 □Unknown
	Completed	Ischemic andiomy opathy	24a. Was ar autopsy	y prior to c	opsy findings available ompletion of cause of
(RW) Ital Rec ian: The lav	Con	It y per tension	perform	ned? death? ☑ No 1 ☐ Yes	2 🗆 No
of Vita Physician:	Be	eyaminer?	th (Check only one	θ)	TI .
of \Physical Of rall direction	P			nce 6 Other (Spec	MI OSPICE
On On Ging F	lon	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 2 Natural 5 □ Pending investigation 2 Natural 5 □ Pending (Month, Day Year) 3 Natural 5 □ Pending (Month, Day Year) 4 Natural 5 □ Pending (Month, Day Year) 5 Natural 5 □ Pending (Month, Day Year) 6 Natural 7 □ Yes 2 □ No	28d. Describe hor	w injury occurred	
Division of Vital For a stranging Physician: The affect death. Director: After this certificate in by the funeral director, pag	icat	3 Suicide 6 Could not be 380 Place of Injury. At home form street factors office	28f. Location (Str.	reet and Number or Rui	al Route Number
Division tospital or Attending hours after death. Unersal Director: After its filled in by the fune sty filled in by the fune	Certification;	4 Homicide determined building, etc. (Specify)	City or Town,		
Hospital Hospital Hospital Holy filled		29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place,	and due to the ca	use(s) and manner as	stated.
Division of Vital Recomplished Brown of Vital Recomplished Programmers after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occur one) and manner stated.	red at the time, da	ate and place, and due	to the cause(s)
To the within To the comp	Σ	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month	Day, Year)
		If thethong lily, no D25205	A	tpr. 69,	2005
1		30. Name and address of person who completed cause of seath (Item 23a) (Type, Print)	02.	nd 2:2	06
		1. A. R. (ey CBMC 6701 N. Charle St. Bo 31. Date filed (Month, Day, Year) 32. Registrar's Institute	ero.	010 616	
S Regi	State strar	31. Date filed (Month, Day, Year) APR 12 2005 Seem & Specific			
		WELL TO FOOD POSSESS 20 1			

			Please	Type or Print in Blacl	c Indelible Ink	L Ensure All	Copies A	re Legible.	
			1 - For State Registrar	State of Maryland / D		Health and Me	-	ne 1115	12459
	Dhun!s		1. Decedent's Name (First, Middle, Las	st)			. Date of Death		3. Time of Death
	Physici /Medi			Watcheski			oril 1	0 2005	12:45 A M
7	Examir	er	4a. Facility Name (If not institution, give Stella Maris	street and number)	4b. City, Town,	or Location of Death		4c. County of Death Baltimore	
	Ermanal		5. Social Security Number 6. Se	ex , 7. Age (In yrs. last birt		If Under 24 Hrs. 8	. Date of Birth	9. Birthi	place (State or Foreign
	Funeral Director		214-03-2405 Usual Residence of Decedent	Ou office	rs. Months Days	Hours Min.	Month, Day, Ye	914 Mary	place (State or Foreign ntry) land
	ryland	_	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	8a-f	cto	MD Baltimore	e Timoniu					1 ☐ Yes 2 🛣 No
	with the	Funeral Director	10e. Street and Number 2300 Dulaney Val	lev Poad	10f. Zip Code 21093			Citizen of What Cou	ntry?
	Jeath Trs 23	era	11. Marital Status	12. Was Decedent Ever in U.S.		Hispanic Origin? (Speci pan, Mexican, Puerto Ri		14. Race - Ameri	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event. It a Medical Examiner must be notified at Ance.	by Fun	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	If Yes, specify Cub		ćan, etc.)	Black, White, Specify: Whi	
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	lucation 16a. de completed)	! Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of working	166	. Kind of Business/In	dustry
121	within ene. than "	Completed by	Elementary/Secondary (0-12)	College (1-40r 5+)	life. DO NOT use retire lf Employed		l	rocery Sto	ro
d 2	filled Hygid other ent.	e Co	17. Father's Name (First, Middle, Last)		ii Emproyed	18. Mother's Name (1 6
lan	lid be fental rked tlc ev	To Be	Stephen Novak			Marcyanna	Pila	rska	
Maryland 21215-0036	nd 2 should be filed within ? lith and Mental Hygiene. 27 is marked other than " r traumatic event. It e Med		19a. Informant's Name/Relationship (7 Carolyn W. Hanson		Mailing Address (Street D Beech Vie				Code)
Baltimore,	of Head		20a. Method of Disposition 1	comoton	Disposition (Name of r, crematory or other pla	Dat		. Location - City or To	
Ë	Pag tment tant: jury c		4 □Donation 5 □ Other (Specify) Holy Cro	ss Polish Nat			undalk, MD	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licen	Ž.	22. Name and Addre	n Funeral b		1050 York Towson, MD	
	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olication hat caused the death. Do none cau e on each line. INANITION	ot enter the mode of dyi	ng, such as cardiac or r	espiratory arrest,	ī	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequence of	f):				
		aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	bDue to (or as a consequence o	f):				
oʻ.	executed an and rial-transit	Ехап	that initiated events resulting in death) Last	cDue to (or as a consequence o	f):				
68760,	ate be hysicia the bu	licai		d					
O. Box	that the death certificate be exe ed by the attending physician at detached for use as the buriah-t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 N No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnanc	у		23d. Date of delive Month	ery Day Year
<u>α</u>	w requires that the been signed by the should be detache	by	Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause gr	ven in Part I.		co use contribute to the	ne cause of death?
Records,	law req as beer 2 shou	Completed					24a. Was an	24b. Were auto	psy findings available
- Re	sician: The law s certificate has b irector, page 2 s	mo					autopsy performed 1 ☐ Yes 2 🛣	? death?	mpletion of cause of 2 No
Vital	ystclan: is certifica director.	Be	25. Was case referred to medical examiner?			26. Place of Death (0			
of V	A .00 D	2	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA			6 ☐Other (Specifi	y)
	ding After fune	tion:	27. Manner of Death 1 X Natural 5 Pending investigation		jury Wo	ryat 280 rk? Yes 2 □ No	d. Describe how in	njury occurred	
Division	f or Attending after death. Director: After I in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined				. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
-	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical Co	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Syamone)	ysician: To the best of my knowledge, liner: On the basis of examination and and manner stated.	death occurred at the ti	me, date and place, and opinion, death occurred	d due to the cause at the time, date	e(s) and manner as si and place, and due to	rated. the cause(s)
	o the ithin (o the omple	Mec	29b. Signature and title of certifier	and mainter stated.	29c. Licens	se number	29d.	Date signed (Month,	Day, Year)
	F 3 F 8			/	D			11/11/06	

518 State

 DR. TARIQ MAHMOOD
 2300

 31. Date filed (Month, Day, Year)
 32. Reg

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093
32. Registrar's Signature

APR 1 2 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stem & Speller ORIGINAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Gregory Jones Winder State of Maryland / Department of Health and Mental Hygiene 05 - 2484For State Unpend Item 23a, pt.II, 27 per mentile at 1993 tas DOS 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) April 09, Physician Winder 2005 1145 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** 1307 Ostend Street Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 10M 20F 215-46-9698 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d, Inside City Limits 77 Is marked other than "netural", or Items 23a or 28a-f show traumatic evant, the Medical Examiner must be notified at 1 Nes 2 No Directo Maryland 10e. Street and Number 10g. Citizen of What Country? 1307 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. nt: If Itam 27 Is marked other than "netural", or Items 23 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) TI SING Elementary/Secondary (0-12) College (1-4or 5+) Deliveryman 17. Father's Name (First, Migdle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be Keaustus Dres 19a. Informant's Name/Relatio ship (Type, Department of Health a Important: If Itam 27 Is any injury or other trac Sandored han 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Oly or Town State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service L Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician aHypertensive Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed use as the burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Cirrhosis of the Liver Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \sum No 24a Was an certificate has autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) at Scene 1 🔀 Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Hospital or Attending Pl
 A hours after death.
 Funaral Diractor: After the 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie, April 10, 2005 OCME ne and address of person who completed cause of death (Item 23a) (Type, Print) OK A11 Penn Street Baltimore MD 21201

State Registrar

2005 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** WHITE 6:00 PM 04 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Dealt 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring

If Under 1 Year If Under 24 Hrs.

Months Days House Montgomery Maringer Health 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 ☐ F 79 Yrs. 22. Jamaica Director 218-66-<u>6057</u> Mar Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show Examiner must be notified at 1 TaYes 2 No Director Silver Spring Montgomery 10g. Cilizen of What Country? 10f. Zip Code 10e. Street and Number with 901 Arcola Avenue 20902 U.S.A. or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Peges 1 and 2 should be filed within 72 hours after of meath and Mental Hygiene. The least it flem 27 is marked other than "natural", or flee ury or other traumatic event, the Medical Experimentry or other traumatic event, the Medical Experimentry. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No by Specify: **Black** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Environmental Service Tech Health Care 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert White Kathleen Griffth 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Winston L. White- Son 7100 Taylor Street Hyattsville Md 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1
Department of H
Important; If Ite
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Fort Lincoln Cemetery 4/16/05 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee Þ 3401 Bladensburg Road Brentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARRYTHMIA **Physician** disease or condition resulting in death) /Medical Examiner IL EUS NON OBSTRUCTIVE 5 years itially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) -burialattending physicien P.O. Box 68760 Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached the th 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be Melletus 2 2 No 3 Probably 4 Unknown Completed tension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospilal: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Aursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 🛮 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the P 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 04/06/2005 058962 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2309 SHOREFIELD ROAD, WH 31. Date filed (Month, Day, Year) 32. Segistrar's Signature MD 20902 WHEATON 31. Date filed (Month, Day, Year) State 2005 LOGIAS. Registrar

WDE	W MITHT	ATT.	For	State of Maryland / Dep		∕lental Hygi	ene 005	12462
			State Registrar		ertificate of Death	Re 2. Date of Death	g. No.	1 1 7 0 1
	Physicia		1. Decedent's Name (First, Middle, Last	1 1 1		Month	7, Day 2005 Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	Ctroot and number)	4b. City, Town, or Location of Death	<u> </u>	4c. County, of Death	1007
4	Examin	er	501 WEST FRANKLIN	STREET APT.427	BALTIMORE CITY		NA	
	Funeral		5. Social Security Number 6. Se	hi all -) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthi	place (State or Foreign
н	Director		212 -28-0948	M 2 F Yrs.		HPR 8,1	933 MA	try And
	land	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Mary -f sh	ţ	md N/R	15AH	4 more			11 Yes 2 □ No
	n the	Director	10e. Street and Number	71511	10f. Zip Code	10	g. Citizen of What Cou	ntry?
	death with the Maryland ms 23e or 28e-f show	la D	713 EAST	dl st.	21218		NBH	
		Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race · Ameri Black, White,	
36	hours after tural, or ite	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: 3/	Ack
5-0036	72 hours natural', deal Ex		15. Decedent's Edu	cation 16a. Dec	edent's Usual Occupation	king 1	6b. Kind of Business/Ir	duginy mic A
7	C 3	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	(Anton	JETHON E
7	e filed wi		7/1		- DORER	ne (First, Middle, M	Inidon Sumamol	
Maryland	0 = 0 %	Be	17. Father's Name (First, Middle, Last)	in the	Ann	E (1)	MAM	6
Ž	should be nd Menta marked matic ev	ဥ	CROWDER C	(pe, Print) 19b. Mai	ling Address (Street and Number or Ru	ral Route Number,		
	nd 2 salth ar 27 is r trau		JEANINE	Williams 71	3 FAST 21SI	St. B	4/to.m	0-21218
re,	is 1 ar		20a. Method of Disposition	20b. Place of Disp	position (Name of ematory or other place)		Oc. Location - City or T	
m	Page nent o ant: If ary or		1 Burial 2 Cremation 3 II 1 Other (Specify)	Temoval nom State	metery 4/1	4/05 0	MARRISO	n nd
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Ligens	ans ones	PARTY AND ASS OF Facility	JON ED WAY B	Atto, ma	1.31213
	*		23a. Part1. Enter the disease, or comp	lications that caused the death. Do not en	nter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	DEDUKING COMPL				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	1	_		
	LAMITHIE	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Unr DUSE 135 Due to (or as a consequence of):				
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· ,	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
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			IF FEMALE:					
Вох	The law requires that the death certifi te has been signed by the attending vage 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 5 9 Unknown	Other (specify)			
P.0	that the de led by the detached	/Ph	Part II. Other significant conditions co	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	he cause of death?
rds	quires n sign uld be	ed by				1 🗀 Ye	s 2 1 √ 0 3 □ Pro	bably 4 Unknown
00	aw requir as been s 2 should	Completed				24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
Re		mo				erform	ed? death?	2□ No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			th (Check only one		
Division of Vital Records,	Attending Physician: r death. ector: After this certifica by the funeral director.	2	Yes 2□No	Hospital: 1 Inpatient 2 ER/Outpati		ome 5 Resider	nce 6 KOther (Speci	fy) AT SCENE
on C	Jing F	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	_	D Rown	DIN TUB
isi	l or Attendi after death. Director: A in by the fu	flcat	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s building, etc. (Specify)	10	28f. Location (Str	eet and Number or Rur	
Ö	al or / s after I Dire	erti	4 ☐ Homicide determined	building, etc. (Specify)	LOWE	City or Town		AUTHORS MIN
	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t	edical (29a. Certifier 1 Certifying Phyone Check only one	vsician: To the best of my knowledge, de- iner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	and due to the ca	use(s) and manner as :	stated.
	To the within 2 To the comple	Me	29b. Signature and title of certifier	L	29c. License number	29	APRIL 9,	Day, Year) 2005
			Maughte In	e shele	OCME		ALKIL 7,	
	ALA			completed cause of death (Item 23a) (Type		TTMODE NO	ADSZT AND OLO	01
	3+1		MANUA M TO 31. Date filed (Month, Day, Year)		11 PENN STREET, BAL	TIMORE, MA	AKILAND ZIZ	OT
	Sta Regist		APR 12	32. Registrar's Signature	Charles .			
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05- 2342 B.K.S BERNARD WRIGHT 5th

			State of Maryla State of Maryla 23a,27,28a-f p. 1. Decedent's Name (First, Middle, Last)	re me	tificate of	Déath ^s	2. Date of De	-		3. Time of Death
	Physici		Bernard Char	les Wri	ght, 5th		APR TI	Day 3 20	Year	1056 AM
7	/Medi Examir		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County	of Death	
			HARBOR HOSPITAL			ORE CITY			/A	
3	Funeral		5. Social Security Number 6. Sex 1 № M 2 □ F 7. Age (In yrs	s. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	nth ay, Year)	Coun	
	Director		Usual Residence of Decedent		4 1		Dec. 2	, 2004	Mar	yland
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	Ba-1 s	Director	Maryland N/A	Baltimo				10.00		1 🛣 Yes 2 🗆 No
	Min u		100. Street and Number 1010 Stoll Place		10f. Zip Code	225		10g. Citizen of V		ntry?
į	ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in	U.S. 13. \		ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or N		e - Americ	ean Indian,
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121	Hygier Than ti		17. Father's Name (First, Middle, Last)	None	- infan	t 18. Mother's Nam	e /First Middle	N/A	(a)	
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Maryland 21215-0036	th and I th and I the me traume		19a. Informant's Name/Relationship (Type, Print) William Gunn / Grandfather		-	_{and Number or Rur} venue Ba			-	
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Baltimore,	Departn Departn Imports any inju		21. Signature of Funeral Service Licensee	1/-		ss of Facility G				•
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	hysician /Medical public years and public years with a private result of the private res	dical Examiner	Immediate Cause (Final disease or conditions resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consection of the conditions).	equence of):	Death in	Infancy				
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	to train rospine of Attaining rivariant. The within 24 hours after death. To that Funeral Brector: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my kr 2 Medicel Exeminer: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the timestigation, in my o	ne, date and place.	and due to the	cause(s) and ma	nner as st	ated. the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier Taylo 2 Melnkere	MA	29c. License OC.			29d. Date signed APRIL		
			30. Name and address of person who completed cause of death (te	em 23a) (Type,		enn Stree	et Balt	imore N	Marv1	and 21201
									THE YEAR	and Lizvi

				nd / Department of Health and M		nen a se a la la la la la la la la la la la la l
			For State Of Ividity to State Of Registrar	Certificate of Death	Reg. I	40404
	Physici	an	Decedent's Name (First, Middle, Last)	3		Day Year 3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	HPIC.	4c. County of Death
	Examin	er	HARLY HOSPIM	BATINIZE		NHA
	Funeral		5. Social Security Number 6. Sex 7. Age (In your	s. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	113.	1-01-3	OZ VA
	anyland show	'n	10a. State 10b. County 10c. C	City, Town or Location		10d, Inside City Limits 1 LTYes 2 □ No
	the Mi	Funeral Director	10e. Street and Nymber	10f. Zip Code	10g.	Citizen of What Country?
	th with	al Di	1205 Asburton Street	21216		USA
	er dea	uner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Caban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc.
036	urs aft	by	1 ☐ Never Married 2 【V Married 1 ☐ Yes. 2 【V No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 M No Specify:		Specify: BAK
2-0	72 ho	leted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work)	ing 16b.	Kind of Business/Industry
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Evertinal relational angles.	To Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	len Sumame)
Maryland	should nd Men marke umatic	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Numbaror Rura	al Route Number, Cit	y or Town, State, Zip Code)
	and 2 s ealth an n 27 ls		Kumberlyon, Walker (Daugh	1 1000 (1)	et bato.	MD 21216
Baltimore,	Pages 1 and of He Int: If item		20a. Method of Disposition 20b.	Place of Disposition (Name of cemetery, crematory or other place)	0	Location - City or Town, State
Ħ.	permit, Page Department Important: If any Injury or once.		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ↑	Reen mount 4-13.		altimore MD ene Funeral Sives
Ba	Depa Impo any I		March Cal	8728 Liberty Rd.	Randalls	tour, mo 2/133
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J Of	ng Phy ter this neral d	on: To	27. Manner of Death 28a. Date of Injury		28d. Describe how in	
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Σ	al or Attend after death I Director: A	Certification:	4 Homicide determined building, etc. (Spe		City or Town, St	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	(Check only 2 Medical Examiner: On the basis of exami-	nowledge, death occurred at the time, date and place, nation and/or investigation, in my opinion, death occurr		
	o the hithin 24 o the homelet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
)	⊢ s ⊢ ŏ		1 Josh Costs M	D 42634	A	on 12,2005
,	d		30. Name and address person who completed cause of death (It	em 23a) (Type, Print) ST-PAUL PVICE (א נדינת	or 12,2005 RE 10 21202
	Sta	ite	31. Date filed (Month, Day, Year) APR 1 2 2005	ST. PAUL PURE I	137611100	C / D CIEVE
	Regist		APR 1 2 2005	O Sparke		

		-	For State Registrar	State of M	arylan	-	artment o			nd Menta		ene g. No.	005	12465
	Physicia /Medio		1. Decedent's Name (First, Middle, JAMES	WILLIAA	is,	JR.				AP 4	of Death of Death 2f	Day 8	2005	3. Time of Death
	Examin		4a. Fecility Name (If not institution,	licalle	leet	(Vast birthday)	4b. City, To	al	opation of	We	of Birth	4c. Co	N A	ago (State or Foreign
	Funeral Director		5. Social Security Mumber 117 - LA - 5084 Usual Residence of Decedent	1 ½ M 2□F	49	Yrs.			Hours	Min. (Mor	nth, Day,)	Year), 156	Coun	ace (State or Foreign try) MD
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"	or Items	Fune	11. Marital Status 1 Never Married 2 Married	12. Was Deceden Armed Forces 1 □ Yes 2 🔀	?					in? (Specify Yes , Puerto Rican, e	itc.)		Black, White,	
21215-0036	72 hours after death naturel', or Items 23	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 □ Yes 2 🛭		Specify:				BUAC	'K
15-	- 33	Completed	15. Decedent's (Specify only highest	grade completed)	5.)	16a. Deced (Give life.	dent's Usual C kind of work o DO NOT use i	Occupation done duri retired)	on ring most	of working	16	6b. Kind	of Business/Inc	lustry
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and	should be filed within and Mental Hygiene. marked other then imatic event, the M	Be	17. Father's Name (First, Middle, La							r's Name (First, i SHANK		aiden Su	mame)	
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	ss 1 and 2 of Health of item 27 is		KISSAUNDRA WI	LLIAMS	Jack B		W. LAN	-	E S	1. BAL		MD	21217	um State
Baltimore,	# O		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		, , ,	EEUMI	natory or othe	or place)	10.	4 - 12 - 05			tion - City or To	wn, State
altin	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Services i	ensee	IGH	22	Name and	Address	of Facility	/	E	MUL	. 1010	
ä			John Wit	Liamo				10.1	JATL'	PIKE, E	ALTO.		21229	
	Physician		23a. Part. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that cause his one cause on each	ine.	Do not ent	er the mode o	of dying, s	such as c	cardiac or respira	atory arres	st,	4	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to or a	s a conseq	uence of):	01111	c.						dans
1	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s onseq	uence of):	cuc							carage
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	s a conseq	uence of):								
8760	ate be on hysician he buri	Ical	,	d			<u></u>							
9	eath certifice attending ph I for use as th	/Med	IF FEMALE:	23c. If yes, outcom	e of pregna	incy						230	d. Date of delive	rv
.O. Box	The law requires that the death certificate ten as been signed by the attending physoage 2 should be detached for use as the	by Physician/Mec	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown			Ectopic pregi Other (speci							Day Year
rds, P	w requires that been signed t should be det	d by P	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying caus	se given	in Part I.	236	o. Did toba 1 ☐ Yes			e cause of death? ably 4 Unknown
of Vital Records,	The law re- ate has bee page 2 sho	ompleted	hopat	this C	refer	chin					a. Was an autopsy performe	ad?	death?	osy findings available inpletion of cause of
ital		Be Co	25. Was case referred to medical					2	26. Place	of Death (Check)	1 🗆 Yes	2 140
of V	Physicien: this certific	ို	examiner? 1 Yes 2 No	Hospital:		ER/Outpatier		Other:	4 🔲 Nui	rsing Home 5				')
on (ting After fune	tlon:	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	ay Year)	28b. Time o Injury	M 280	. Injury at Work? 1 ☐ Ye	ıτ ns 2∐N		scribe how	v injury o	ccurred	
Division	Hospital or Attending 44 hours after death. Funerel Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could no determin	t be 28e. Place of le	njury - At ho atc. (Specif		reet, factory, o	office			ation (Stre or Town,		Number or Rura	l Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C		Physician: To the bes keminer: On the basis and manners	of examina									
	To the within 2 To the complet	Me	29b. Signature and title of certifier	(() ()	ATT	MONE	6 29c. L	icense n	number		290	d. Date s	signed (Month,	Dey, Year)
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r	\mathcal{Y}		J.NYZARTA	ho completed cause of	301	ST. /	AUC S	T.	Ba	ltrueor	e, ill	io.	21201	
	Sta Registr		31. Date filed (Month, Day, Year) APR 12	2005 32 Regis	trar's Signa	y So	este							

			For State Registrar	State of	Marylan		artment of h		and Men	tal Hygie	71115	12466
- Ņ		,	Decedent's Name (First, Middle	e, Last)	_					Date of Death Month	Day Yee	3. Time of Death
	Physici /Medio		Hilleard	White	e					arch 29	, 2005	2:20 a M
) and	Examin		4a. Facility Name (If not institution				4b. City, Town, o		of Death		4c. County of De	eth
			Prince George's				Chever		24 Hrs. 0, 5	Data of Blah	P.G.	
Е	Funeral		5. Social Security Number 579–70–3536	6. Sex 7 1 M 2 □ F	7. Age (In yrs. 52	Yrs.	Months Days	Hours	Min. 8. C	Date of Birth Month, Day, Ye 2/04/195	ar) [47]	inthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	Λ	32				12	2/04/13.	oz wa	shington, DC
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	e Ma	ctor	MD PC	3		Sui	tland					1 Yes 2 No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g.	Citizen of What	
	s 23s	rai	3607 Woodcreek		4 Francisco	6 140		746	nin2 (Canaih)	Van ar Na	U.S.A	nerican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural; or Items 23e or 28e-f show any follury or other traumatic event, the Medical Exert are mail to mailing a page.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marr 3 □ Widowed 4 □ Divorced	If Yes, Give	ces? 2 🔲 No		Was Decedent of I f Yes, specify Cub 1 □ Yes 2½ No		n, Puerto Rica	n, etc.)	Black, Wi	nite, etc.
ğ	2 hou	ted	15. Deceden				dent's Usual Occup		t of working	16b	. Kind of Busines	s/Industry
21215-0036	thin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-	4or 5+)	lite.	DO NOT use retire	d)	. or working			
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2	should nd Men marke umatic	7	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street				y or Town, State	. Zip Code) 20011
	and 2 sealth ar n 27 is		Leroy White - E				New Hemp					gton, DC
ē,	s 1 ar		20a. Method of Disposition			Place of Dispo	sition (Name of matory or other pla	1	Date		Location - City	
E	Pages nent of i int: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ∐Removal from S pecify)	tate	•	Cremato		4/6/200)5 Ri	verdale	. MD
altimore,	permit. Departn Imports any inju		21. Signature of Funeral Service	Licensee		22	. Name and Addre	ess of Facility	y Freen	an Fune	ral Ser	vices
<u> </u>	80559		Lender	Deenu		P	.O. Box	416; 5	Suitlar	nd, Mary	land 2	0743
3			23a. Part I. Enter the disease, or shock or heart failure. List	\ /					cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a			ficiency					
R	/Medical Examiner		,	Due to (c	or as a conseq	uence of):						
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8760,	cate be executed oblysicien and the burial-transit	dicai		d								-
9	death certificate be executed e attending physicien and of for use as the burial-transit	Med	IF FEMALE:	23c. If yes, outc	ome of present	now.					2010	
Вох	attenc for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 ☐ Fete nt at time of d	I death 3	Ectopic pregnanc Other (specify)	у			23d. Date of d Month	Day Year
P.O.	that the de led by the a detached f	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno								
	res that igned by be deta	by Pr	Part II. Other significant condition	ons contributing to dea	ath but not res	ulting in the u	nderlying cause giv	ven in Part 1.		23e. Did tobaco	o use contribute	to the cause of death?
rds	w require: been sig should b	q pa	End Stage Re	nal Diseas	se					1 🗌 Yes	2000 3□1	Probably 4 Unknown
Vital Records,	2 S B	Completed	Symtomatic H	HIV					[:	24a. Was an autopsy	24b. Were	autopsy findings available completion of cause of
Ž.	The ate h	mo:	Pneumonia							performed 1 ☐ Yes 2 ☐ X	? death?	2 1
/ita	Physician: Th this certificate ral director, paq	Be (25. Was case referred to medical examiner?				lau		of Death (Ch	eck only one)		`
of/	Physic this c	2	1 ☐ Yes 2 No			ER/Outpatien		4 Nu			6 □Other (Sp	ecify)
L C	Jing F After funer	ilon	27. Manner of Death Natural 5 Pendin investig	g ·	Day Year)	28b. Time of Injury	Wo	rk? !Yes 2.⊟1		Describe how in	ijury occurred	
Division	or Attending after death. Director; After in by the fune	ficat	3 Suicide 6 Could i	not be aga Blace	of Injury - At ho	ome, farm, str	eet, factory, office		28f. L			Rural Route Number,
5	afor after Directory	Certification:	4 Homicide	buildin	g, etc. (Specify	y)			(City or Town, St	ate)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (g Physician: To the t Examiner: On the ba- and manne	sis of examina							
	To the within 2 To the complet	Σ	29b. Signature and title of certified	Munn	\		29c. Licens	se number		I	Date signed (Moi	**
,	0		Ellest	1 Million) im	7	109	2295	8	w	arech	4,1005
_	1		30. Name and advers of person	who completed cause	5 Green	way (Print) Penter Dr	we#	207G	reenbe	4 MD	29,2005 20770.
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2	2005 32, Re	gistrar's Signa	iture (alle				/	

State of Maryland / Department of Health and Mental Hygiene 🕦 🎧 🖔 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) WHYE Month Day Yee **Physician** 1025AM JACQUELYN APPIL 200 3 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL HOPKINS 5. 8. Date of Birth (Month, Day, Year) 10-24-58 Baltimore 1DHN3 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕱 F Yrs. MĎ 46 Director 217-76-0852 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ral', or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 218 S. Mason Ct. USA Funeral 21231 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other then "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No SpecifyBlack Specify: þ 3 ☐ Widowed 4 ☐ Divorced or then "natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oueen Esther McColl Eugene Whye ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar important: If Item 27 is eny injury or other trau 900. Mason Ct. Balto. MD 21231 218 S. Ethel M. Jenkins 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Sacred Heart 4-13-05 Dundalk, MD 22. Name and Address of FacilityWesley Chavis Jr. 21. Signature of Funeral Service Licensee 2007 Eastern Ave. Balto. MD 21231 23a. Part. Enter the disease of complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure dist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BOWF L **Physician** /Medical YEARS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 th Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 M No 1 📓 Inpatient ဥ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 Tes 2 No 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Funeral within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier RES-ODD APRIL KIRKTO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL GOONWOLFE STR BALTIMORE MO 21287 DORISLAN MRISTON THE SORNS NOPKIM 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 2 2005 Registrar

			For State Registrar		yland / Depa		Health a	nd Mental Hygi	ene 2005	12468
			Negistrar Negent's Name (First, Middle, Last))				2. Date of Death		3. Time of Death
*	Physicia	-	Helen E. Yeisl					April	7 2005	1:30P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death						4c. County of Deat	
	LAUITIII		Copper Ridge Nurs			Sykes	sville		Carrol	L
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days		4 Hrs. 8. Date of Birth Min. (Month, Day,	Year) 9. Birt	hplace (State or Foreign
	Director		141-09-2190	M 20XF	85 Yrs.			Oct. 21	,1919 New	Jersey
	within 72 hours after death with the Maryland liene. I then "natural; or Items 23e or 28e-f show the Marical Examiner must be notified at	Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
										1XXves 2 □ No
			N.J. Union		Linde	10f. Zip Code		10	g. Citizen of What Co	ountry?
				. 4-			7036		U.S.A.	
9			931 Summit Stree	12. Was Decedent Ev	er in U.S. 13.			in? (Specify Yes or No-	14. Race - Ame	
			1 Never Married 2 Married 1 ☐ Yes 2 No				Decedent of Hispanic Origin? (Specify Yes or No- , specify Cuban, Mexican, Puerto Rican, etc.)			Black, White, etc.
Ö			3 ☐ Widowed 4 ☐ Divorced If ∀es, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify:						Specify: V	White
5-0			15. Decedent's Edu (Specify only highest grad		16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most	of working	6b. Kind of Business/	Industry
21			Elementary/Secondary (0-12)	College (1-4or 5+)					T	
2	e filed will Hygier other ti		12 17. Father's Name (First, Middle, Last)		Lega	al Secret		's Name (First, Middle, M	Law	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Importent: If Item 27 le marked othe any Injury or other treumetic event, ORE.	To Be	Michael Zavoda					la Smayda	alder Gallianie,	
			19a. Informant's Name/Relationship (Ty	rpa, Print)	19b. Mailie	na Address (Street		or Rural Route Number,	City or Town, State, 2	Zip Code)
			William A. Yeisle		nd) 931 S	Summit St	reet	Linden, New	Jersey 07	7036
ē,			20a. Method of Disposition		20b. Place of Dispo	sition (Name of	ice)	Date 2	Oc. Location - City or	Town, State
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☑ F `4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Grace Land Park	l Memoria	iI Z	4-12-2005 K	enilworth,	New Jersey
			21. Signature of Faneral Service Licens					Homes, Inc.		
			Deman	Mals	- Nel 55	555 Twin	Knolls	Road Colu	mbia, Mary	land 21045
Ye	/Medical Examiner and private in	niner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between							
			Immediate Cause (Final disease or condition	Peri	Co/0.	ns c	MAS	22 9-3 7		Onset and Death
			resulting in death)	Due to (or as a	consequence of):					
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89	tificat og phy as th									
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			in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							
P.0		Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 239. Did tobacco use contribute to the cause of death?							the cause of death?
Records,		l by	1 ☐ Yes 2 ☑ No 3 ☐ Pro							
		etec						24a. Was an	24h. Were au	itopsy findings available
Rec		o Be Completed						autopsy perform	ed? prior to death?	completion of cause of
Division of Vital I			25. Was case referred to medical 26. Place of Death (Check only one)							
			25. Was case referred to medical seaminer? 1 Yes 2 No							
		n: T	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred						
		ertification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	M 1 □ Yes 2 □ No						
Ν		tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		O								
		edical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 2 Medicel Exeminer: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	o the	Me	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (Mont	h, Day, Year)
)	->		296. Signature and title of Certifier	// ·	mo	03	588	2	4/7/05	
	25		30. Name and address of person who co	ompleted cause of dea	ith (Item 23a) (Type,	Print) Cx.	-1.	O. Rais	freshorn.	ml 21135
State Registrar			29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature							

			1 = For State of Mary		artment of h			iene 0 0 5	12469
			Decedent's Name (First, Middle, Last)				2. Date of Deat	1	3. Time of Death
	Physici		ROLAND ZEN	172			APRIL	Day Year	236m
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	th P
	Examin		NONTHWEST HOSPITAL CE	NEN	RANGE	21670	. 1	BAITIN	Des-
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	II Under 1 Year		8. Date of Birth		hnlace (State or Foreign
	Director		215-20-7932 15XM 20F	78 Yrs.	Months Days	Hours Min.	Feb. 7,	1927	Maryland
	PL _		Usual Residence of Decedent	0h 7					
	arylec	_	10a. State 10b. County 10c Md. Baltimore	Reister					10d. Inside City Limits
	Be-f	cto		1.010001					1 Yes 2 No
	72 hours after death with the Marylend Inclurel', or Items 23e or 28e-f show dical Exambra Inustice Indiffed at	Funeral Director	10e. Street and Number		10f. Zip Code	37/	10	g. Citizen of What Co	
	s 23e	rai	300 Cantata Ct. Apr. 330	1-110		136	4 14	U.S.A	
	er de	nue	11. Marital Status 12. Was Decedent Ever Armed Forces? 1. 12. Never Married 2 □ Married 1. 12. Was Decedent Ever Armed Forces? 1. 12. Yes 2 □ No ↓	IN U.S. 13.	Was Decedent of H If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	14. Race - Ame Black, Whit	
36	rs aft	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	AM II	1 ☐ Yes 2 🛣 No	Specify:		Specify: W	nite
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715	nin 72 n *ne Medi	piet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wor d)	king		
2	d with	Completed	12	S	cretary			Develope	ement Co.
	othe othe	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, M	laiden Surname)	
/lai	uld b Menta Irked	To	Earl W. Zentz			Ethel	Pittinge	r	
Maryland	2 sho and 1 le me		19a. Informant's Name/Relationship (Type, Print)	1	-			City or Town, State, 2	
	and ealth m 27 ner tr		Charles E.N. Murray - Nephev			race Dr.	-	stown, Md.	
ore	ot H of H if ite		14 Burial 2 Compation 2 Deamousl from State		matory or other plac			0c. Location - City or	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Importent: If them 27 le marked other then "neturel; or Items 23e or 28e-1 show any injury or other treumetic event, In a Marchal Example, in the indifficit at once.		21. Signature of Funeral Service Licensee	22	Eckhard	t Funeral	Chapel,	P.A. Owings Mil	21117
			23a. Part . Enter the disease, or complications that caused the	death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	owings Mil.	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final		00.1	26. 1	15100	- 1	Interval Between Onset and Death
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Н	Examiner								
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nsequence or).					
	ate be executed hysician and the burial-transit	Examiner	that initiated events						
ő	e exe ian a urial-	Ä	resulting in death) Last Due to (or as a con	nsequence of):					
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	ledicai	d						
9	death certifica attending ph	Me	IF FEMALE:						
Вох	ath c	ian/	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnancy	1		23d. Date of deli	very Day Year
о О	that the death cer ed by the attendin detached tor use	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	of death 5	Other (specify)				
۵.	hat ti	P	Part II. Other significant conditions contributing to death but not	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds,	ires tha signed d be det	d by			SPOST "			2 □ No 3 □ Pr	_/
Ö	w require been si should b	ete	Antony BypASS AND GRAFT,	1 11-12	105		24-146		6.40
Record	has has	Completed				osis Arto	24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of
	sicien: The certiticate ha rector, page		CANDIONESPINATING ARREST.	OLD ST	neke		1 ☐ Yes 2		2 No
Vita	yeicien: The is certiticate hidirector, page	o Be	25. Was case referred o medical examiner?		Oth		h (Check only one	ce 6 □Other (Spec	
ot	Phys r this ral di	\vdash	1 ☐ Yes 2 ☐ 16 ☐ Prospital 1 ☐ Impatient 27. Mann 1 Death 28a. Date of Injury	28b. Time of			ome 5 Residen 28d. Describe hov		erfy)
on	Attending Physicien: r death. ector: After this certifict by the funeral director.	tion	1 atural 5 Pending (Month, Day Yea	ir) Injury	Wor	k? Yes 2 □ No		,,	
Division of	Attendi death. ctor: A y the tu	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - A	At home, larm, str			28f. Location (Stre	et and Number or Ru	ral Route Number,
2	after Dire	Certification:	4 Homicide building, etc. (Sp.	pecify)	•		City or Town,	State)	
	spite nours nerel		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death	occurred at the tin	ne, date and place,	and due to the cau	se(s) and manner as	stated.
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or inv	estigation, in my o	pinion, death occur	red at the time, dat	e and place, and due	to the cause(s)
	To the To the Comp	Ň	29b. Signature and title of certifier		29c. Licenso			d. Date signed (Month	
1	4		1 (May my	<i>)</i> .	1	9502	A	mil 9	2105
1,	0		30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)	NENTHE	Stay to	Espital	2405 CLUZON 21133
Ų			ORIANDO B. CONANAN	ionatura		PANSHISE	BUN, 1	LASYCAND	21133
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's S APR 1 2 2005	ignature Angel	Brail Barrell			ť	
	- riegisti	-11	The state of the state of	- 10					

				1 - State of Maryland / Dep	partment of Health and I		giene () ()	5 12470
		Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of De	ath	3. Time of Death
4	Age .	⇒ /Medi	cal	Marie Amoroso	· · · · · · · · · · · · · · · · · · ·	April	9, 200	
	زر	Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	h	4c. County o	
		Funeral		Upper Chesapeake Medical Campus 5. Social Security Number 6. Sex 7. Age (In yrs. Jast birthday	Bel Air) If Under 1 Year If Under 24 Hrs.	9 Date of Bird	lb.	Harford
	- 1	Director		180-16-4715 1□ M 21XF 81 Yrs.	Months Days Hours Min.		1923 1	9. Birthplace (State or Foreign Country) PENNS YLVANIA
		put *		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or I		Theod of	7723	Chrogeouna
_		Aaryla Fahor	ō					10d. Inside City Limits 1 1 Yes 2 □ No
2		the N 28a-f	Director	10e. Street and Number	Lendale 101. Zip Code		10- 00	
9		3a or	Ö	437 Golden Isles Drive, Unit 5-D	33009		10g. Citizen of Wi	
24:16 AM		deatl	Funeral		Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No	14. Race	- American Indian,
I	36	or Ite		1 Never Married 2 Married 1 Yes 200 No	1 ☐ Yes 2X No Specify:	o Rican, etc.)		White, etc.
Q	Ö	172 hours after death with the Marylar "natural", or Items 23a or 28a-f ahow cdical Exama artifust be notified at	ed by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:				White
	15	in 72 n "na	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation s kind of work done during most of work DO NOT use retired)	king	16b. Kind of Busi	ness/Industry
10	212	d with giene er tha	mo	College (1-4015+)	nemaker		Ot	wn Home
10	pu	al Hy d other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle,	Maiden Surname)	
9	yla	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f ahow aumatic event, the Madical Exameratings or colified at	P	Joseph Manchino	Mary			
419105	Maryland 21215-0036	ges 1 and 2 should be filed within 72 hr it of Health and Mental Hygiene. If frem 27 la markend other than "natu or other traumatic event, the Madical			ng Address (Street and Number or Ru			
		1 and Healt tem 2			Llanfair Rd., Wyr	newood,		
	Baltimore,	t. Pages 1 and 2 tment of Health tant: If item 27 li jury or other tra			matory or other place)		20c. Location - Ci	
	ij	permit. Pa Departmen Important: any injury once.		The cy Creek			Yeadon, 1	
	Ä	Der Imp			9705 Belair Rd., B	enumuner Baltimor	Funeral o MD 21:	Homes 136
				23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory are	rest,	Approximate Interval Between
	7	Priysician		Immediate Cause (Final disease or condition	sator Friluse			Onset and Death
	1	/Medical Examiner		resulting in death) Due to (or as a consequence):	, J carros	*		- Carrys
10			-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	iomas			weeks
7	17	uted d ansit	Examiner	cause. Enter Underlying	iraTory Failure			6
9	o,	an andrial-tra	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence of:	ratory Faiture			weeks
34945	8760	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial transit	dical	· Severe Cache	xia			months
7	9	ertifica ling ph e as t	Med	IF FEMALE:				
MC#	Вох	uires that the death certific signed by the attending p d be detached for use as	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of	
2	P.0.	the de	ysic	in the past 12 months? 1 □ Yes 2 No 4 □ Pregnant at time of death 5 □ 9 □ Unknown 9 □ Unknown	Other (specify)		Wichita	Day Teal
5		that hed by deta		Partill Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?
	rds	quires	ed by	Depressive Disorder due to great,	Chronic recurrent	7 1 □ Ye		Probably 4 Unknown
Ę	Records,	taw requir as been si 2 should	piet	Preumonias -		24a. Was a	n 24b, Wei	re autopsy findings available
4	_		Completed			autops perform	ned? prio	r to completion of cause of
3	Vital	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?	26. Place of Death			Tes Z No
>,<	of \	Phys this al dii	P.	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatien		me 5 Reside	ence 6 Other (Specify)
\mathcal{S}		ing Viter une	tlon:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year)	Work?	28d. Describe ho	w injury occurred	
Ġ	Division	l or Attending after death. Director: After I in by the funer	fica	2 Accident investigation 3 Suicide 6 Could not be determined determined		28f Location /St	reat and Number	or Rural Route Number,
5	Ö	afte Dir	Certificati	4 ☐ Homicide determined building, etc. (Specify)	or, radioly, office	City or Town	n, State)	T Harar House (Variaber,
7 moroso, Marie		Hospital or 14 hours afte Funeral Dire tely filled in b	· 60	29a. Certifier (Check only 2) Medical Examiner: On the best of my knowledge, death	occurred at the time, date and place,	and due to the ca	ause(s) and manne	or as stated.
1		the the the	Medic	one) and manner stated.				
		5 1 5 0 0 V	5	29b. Signature and title of certifier	29c. License number		9d. Date signed (N	
	1	0718		30. Name and address of person who completed cause of death (Item 23a) (Type, F	D-00181	17 (ipril 9	, 2005
	5			ALBERT S. SUN MD 1716 Hart	D-00187 ord Road, Suite 10	5 Fa	ilston 1	17) 21047
	(87)	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature		-,,,		2 4 7 9 7 7
		Registra	ar.	APR 13 2005				

DHMH 17 Rev 1/2001

ORIGINAL

		,	For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of F		_	giene	5	2471
			Decedent's Name (First, Middle,	Last)				2. Date of De	eath Day	Year 3.	Time of Death
	Physici /Medio		John Paul A	inderson_				April			2:00 P M
7.	Examir		4a. Facility Name (If not institution,	give street and number,)		r Location of Deat	h	4c. County		
			Stella Maris			Timon		10.5 (5)		timore	(0)
	Funeral Director		578-36-1157	. Sex 7. A	ge (In yrs. last birthday 76 Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da Dec. 8	^{rth} ay, Υθας) 8, 1928 (9. Birthplace Country) Vashung	(State or Foreign
	and		Usual Residence of Decedent 10a. State, 10b. County		10c. City, Town or L	ocation.				10d. I	Inside City Limits
	Maryi f sho	ō	South Carolina +	lorry	Gande	n City				1	1 ☐ Yes 2 💢 No
	the notified	Director	10e. Street and Number	,0.00		10f. Zip Code			10g. Citizen of W	Vhat Country?	
	h with	0	864 Grand Strai	nd Trail		29576	-8228		u.s.A	١.	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, It a Mysical Examiciar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 🎗 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 X Yes 2 If Yes, Give Year or Dates:	t Ever in U.S. 13. Portean Conflict	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🕅 No		Specify Yes or No to Rican, etc.)	o- 14. Race Blac Specify	e - American Ir k, White, etc. :: Whit	
Š	2 hou	Completed	15. Decedent's	Education	16a Deci	edent's Usual Occup	pation	rkina	16b. Kind of Bu	siness/Industr	Ŋ
215	within 7 iene. than "n	nple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	e kind of work done DO NOT use retire	d)	, many	V avana a s	e e Hann	. / +
2	filed withi Hygiene. other than	S	12th Grade		M	achinist					ifacturin
nd	be file ital Hy id oth	Be	17. Father's Name (First, Middle, La	*				me (First, Middle V. Wil	e, Maiden Sumam o.D	θ)	
yla	2 should be and Mental is marked of sumatic ev	ဥ		erson				_		Charles Tim Con-	4-1
, Maryland	1 and 2 sh Health and tem 27 is m		19a. Informant's Name/Relationshi Douglas M. Ande		n) 1232	ling Address (Street 6 Eastern	Avenue,	Baltimo	ore, MD 2	21220	
Baltimore,	of He	- 8	20a. Method of Disposition 1 □ Burial 2 ★ Cremation	L □Removal from State	20b. Place of Disp cemetery, cre	oosition (Name of ematory or other pla		Date	20c. Location -	•	
Ĕ	permit. Pages : Department of H Important: If Ite any injury or ot		' 4 □ Donation 5 □ Other (Spe	ocity)	Bayview	Crematory			Baltimo,		ıyland
alt	permit. Pag Department mportant: any injury o	1	21. Signature of Funeral Service Li	censes		22. Name and Addre					
	205 29		1 91/10°C	de		9705 Bela					
			23a. P. 11. Enter the disease, or c shock, or heart failure. List o	omplications that cause nly one cause on each	ed the death. Do not el line.	nter the mode of dyi	ng, such as cardia	c or respiratory a	arrest,	inte	proximate erval Between iset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. COLON C	ANCER s a consequence of):						
	Examiner										
		Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence of):						
	cate be executed obysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С.							
o,	an an rial-tr	EX	resulting in death) Last	Due to (or a	s a consequence of):						
8760	ate be nysici he bu	cal		d							_
Box 6	ath certifii ttending p or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Dat Mor	te of delivery nth Day	y Year
P.0	that the de led by the a detached f	Ph	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause gr	ven in Part I.	23e. Did	tobacco use conti	ribute to the ca	ause of death?
d S	signed by	d by		3	J	, , ,		1 🗆	Yes 2□No	3 🗌 Probably	√ 4XDUnknown
Records,	w requir been si should I	Completed						24a. Wa	s an 24h V	Were autoosy	findings available
360	has has	ld m						auto perf	opsy formed?	prior to comple death?	etion of cause of
<u></u>			OS Manager estated to modical				OC Place of De	1 ☐ Yes eath (Check only	-12	1 ☐ Yes 2 ☐] No
of Vital	Physiclan: rthis certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpa	tient 2 ER/Outpati	ent 3 DOA Ot			sidence 6 V Oth	er (Specify) 1	HOSDICE
on of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, E	jury 28b. Time	of 28c. Inju			how injury occurr		IUSI ICE
Division	l or Attending after death. Director: Afte in by the fune	Certification:	2 Accident investigation of Could not determine a control of the could not determine a control of the could not be	of be 28e. Place of I	njury - At home, farm, s etc. (Specify)				(Street and Numb own, State)	er or Rural Ro	oute Number,
	To the Hospital or within 24 hours aft To the Funeral Di completely filled in	al Cer	29a. Certifier Certifying	Physicien: To the bes	st of my knowledge, de	ath occurred at the t	ime, date and place	e, and due to the	e cause(s) and ma	inner as stated	d.
	n 24 he Fu bletel	edical	(Check only 2 Medical E	and manner		investigation, in my	opinion, death occ	urred at the time			
	To the to to to	Σ	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed	d (Month, Day	, Year)
	.1			12			14372	1-1-	4/8	100	
id	TI	~	30. Name and address of person v	no completed cause of	f death (Item 23a) (Typ	e, Print)					
16	1 1		DR. TARIQ MAHN		DULANEY VA	LLEY RD.	TIMONIUN	M, MD 21	093		
		ate	31. Date filed (Month, Day, Year)		strar's Signature	000					
	Regist	_	APR	1 3 2005	fram to	perter					
Dł	HMH 17 Rev 1/2	2001	MI IV		ORIGIN	IAL					
					OTHOUR !						

JOHN PAUL ANDERSON

			1 - For State Registrar	State o	f Maryla	and / Depa	artmen <i>rtificat</i>			ınd Me		ene	05	12472	
	Physici /Medic		1. Decedent's Name (First, Middle, Margaret Bens	,						2	Date of Death Month 4-10-	Dav	Year	3. Time of Death	
	Examin		4a. Facility Name (If not institution, 104 N. Decker Av	enue			Balt	imor	Location o	у		4c. Co	unty of Deati	h	
	Funeral Director		5. Social Security Number 214-50-2784 Usual Residence of Decedent	3. Sex 1 □ M 2√□ F	7. Age (In y 49	rs. last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min. S	Date of Birth (Month, Day, ept 11	1955	9. Birth Co.	nplace (State or Foreign untry))
	ne Maryland 8a-f ahow diffed at	Director	10a. State 10b. County Md		1	City, Town or Lo Baltimo:	re Ci				· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits 1 X Yes 2 ☐ No	
	th with the 23a or 2 ast be no	al Dire	10e. Street and Number 104 N. Decker A	venue			10f. Zip					g. Citizen USA	of What Co	untry?	
036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or items 23a or 28a-f ahow event, I're Medical Exertil varmant be rutilied at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☑ Divorced	12, Was Dece Armed Fo d 1 Tes If Yes, Giv Year or Di	rces? 2 TNo /e X		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		Race - Ame Black, White ecify: whi	e, etc.	
1215-0036	within 72 ho ane. than "natur	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1	-4or 5+)	16a. Dece (Give life. sales	dent's Usua kind of wo DO NOT us	rk done d se retired)	uring most		'		of Business/I	cations	
Baltimore, Maryland 21	0 = 0 \$	To Be Co	17. Father's Name (First, Middle, La William E. Be	nson Jr.			r -		18. Mothe	r's Name (i	First, Middle, M n E. Ev		mame)		
Mar	and 2 should alth and Men 27 is marke or traumatic	•	19a. Informant's Name/Relationshi Ann Harris (sis								Route Number, Ct., Sy			ip Code) Md 21784	
more	mit. Pages 1 and 2 should be triment of Health and Ments portant: If item 27 is marked y injury or other traumatic e		20a. Method of Disposition 1 Naurial 2 Cremation 3 4 Donation 5 Other (Spe		State	o. Place of Dispo cemetery, crei oly Rede	matory or o	ther place		Dat -13-0.			on-City or		
Balti	permit. Page Depertment Important: If any injury o		21. Signature of Funeral Service Li		nt	F .	2. Name an	od Address	s of Facility	Haigl	ht Fune 11e, Md	ral F 217	Home &	Chapel	
	Physician /Medical		23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	nly one cause on e	ach line.	SCV	ter the mod	e of dying	, such as o	cardiac or r	espiratory arre	st,		Approximate Interval Between Onset and Death	
	Examiner	er	Sequentially list conditions,	b	or as a cons		The	tia	/					41	
8/60,	sate be executed by sician and the burial-transit	dical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a cons	D, W 3	ety	, pr	ME	11.7	4			YM	_
O. Box 6	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown		irth 2 ☐ Fi ant at time o	etal death 3	□Ectopic pr □ Other <i>(sp</i>					23d.	Date of deliment	very Day Year	
1	w requires that been signed b should be deta	by	Part II. Other significant condition	s contributing to de	ath but not i	resulting in the u	nderlying c	ause give	n in Part I.		23e. Did toba	1		the cause of death?	
Vital Records,		Completed									24a. Was an autopsy perform 1 Yes 2		b. Were aut prior to c death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of 2 No	
	Phyaician this certif al director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 🔲 I	npatient 2	☐ ER/Outpatier	nt 3 DC)A Othe			Check only one		Other (Spec	ify)	
lon of	nding Ph th. r: After th e funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investiga		of Injury th, Day Year,	28b. Time o Injury	f 2	8c. Injury Work	at ? 'es 2 □ N	286	d. Describe how	injury oc	curred		
DIVISION	To the Hospital or Attending Physician: whilm 24 hours after death To the Funeral Director. After this certification of the funeral director, the funeral director, it	Certification:	3 ☐ Suicide 6 ☐ Could no determin	ed 286. Place buildir	ng, etc. (Spe						City or Town,	State)		ral Route Number,	
	ie Hospi 24 hou ie Funer letely fill	edical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the caminer: On the ba and mann	best of my leasis of exa <i>m</i> ner stated.	knowledge, deatl ination and/or in	h occurred vestigation,	at the time in my op	e, date and inion, deat	d place, and h occurred	d due to the cat at the time, dat	ise(s) and e and plac	I manner as ce, and due	stated. to the cause(s)	
	To the within To the comp	ž	29b. Signature and title of certifier	1	iU			License	number	6		,	gned (Month	-	
1	0		30. Name and address of person w		e of death (I	4		Si							-
F	Sta Registr		31. Date filed (Month, Day, Year)		edstrar's Sig		book	7							_

			1 - For State Registrar	State of N	Marylar		artmen tificate			d Mental H	ygiene	005	12473
	Physici	an	Decedent's Name (First, Middle, Last, Jacqueline			Boy	7			2. Date of t	Death Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give		er)	ьоу		Town, or	Location of D	eath Pr	4c. Co	2005 ounty of Death	1 0
			Stella Maris Me				В	alti	more			NA	
	Funeral Director		5. Social Security Number 6. Sec. 123–54–2690	7. A	Age (In yrs. 57	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 I	fin. 8. Date of E	Birth Day, Year)	9. Birth	nplace (State or Foreign untry) N.C.
	<u> </u>		Usual Residence of Decedent							10-2	20-47		N.C.
	Aarylar F show	ō	10a. State 10b. County NA			ty, Town or Lo							10d. Inside City Limits 1 X Yes 2 □ No
	r 28a-	rect	D.C. INA 10e. Street and Number			Washing	10f. Zip	Code			10g. Citizer	n of What Cou	
	death with the Maryland ms 23a or 28a-f show f must be millied at	raiD	3585 13th Street	N.W.				200	10			USA	
2) 42	after des	Funeral Director	11. Marital Status 1X Never Married 2 Married	12. Was Deceder Armed Forces	s?	.S. 13. V	Vas Deced Yes, spec	ent of His	spanic Origin? n, Mexican, Pi	(Specify Yes or I lerto Rican, etc.)	io- 14.	Race - Ameri Black, White	
/; n & 5-0036	ours af	þ	3 Widowed 4 Divorced	1 ☐ Yes ZX If Yes, Give Year or Dates	s: -	1	∏ Yes 2	K □ No	Specify:		Sp	pecify: B	lack
15-0	n 72 hours "natural", edical Exa	Completed	15. Decedent's Edu (Specify only highest grad	cation completed)		16a. Deced	kind of wor	k done d	urina most of	working	16b. Kind	of Business/Ir	ndustry
2121	d within giene. rr than "	ошо	Elementary/Secondary (0-12) 12th grade	College (1-4o	r 5+)	Cle	00 NOT us ck	e retirea)			Tn		
4 CAU. E.	be filed stal Hygis id other avant, the	Be	17. Father's Name (First, Middle, Last)		D 7					Name (First, Midd		suranc	е
Maryland	should nd Men marka imaric	P P	Oscar 19a. Informant's Name/Relationship (Ty		Boyd,		a Addraga	(Strant a	Rut	:h Rural Route Num	Jon		0.41
, _	is 1 and 2 should be filed within 72 hours after death with the Marylan beatth and Mental Hygiene. Itam 27 is markad other than "natural", or Itams 23a or 28a-f show other traumatic avant, the Medical Examiner must be indiffed at		Pattie M. Boyd	Sist	er					d., Balt			21218
Boyd altimore,	permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 is markad other than "natural", or Itams 23a or 28a-f shov any injury or other traumatic avant. The Medical Examinar must be multified ut once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	emoval from Stat		Place of Disposemetery, crem	sition (Nam	e of her place		Date		tion - City or T	
\$ ≣	artment artmant: ortant: njury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		K	ing Men			4-	·16-05		allsto	wn, Md.
E B	permit. Departn Imports any inju		> & ladus	Wa	nen	"ا د			I. East			rth Ave	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that cause e cause on each	ed the deatl line.	h. Do not ente							Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	• ———	1		enic		9000	1			Onset and Death
	Examiner			Due to (or a	is a conseq	uence of);							
(A)	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseq	uence of):							
6	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or a	s a conseq	uence of):							
8760,	ate be physicia the buri												
9	leath certifica attending ph I for use as th	/Med	IF FEMALE:	a If was autaem	o of over-								
Box.	death c	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcom 1□Live birth 4□Pregnant	2 Fetal	Ideath 3□	Ectopic pre Other (spe				23d	. Date of delive Month	ery Day Year
P.O.	that the de led by the a detached t	hys	9 ☐ Unknown	9□ Unknown									
ds,	igne be c	ρ	Part II. Other significant conditions con	tributing to death	1	ulting in the un	derlying ca	use giver	in Part I.			contribute to tl	he cause of death?
cor	law requir as been si 2 should	Completed		30		2002				24a. Wa			opsy findings available
l Re	The lay	Comp								- auto	opsy ormed?	prior to co death? 1 \(\subseteq \text{Yes}	mpletion of cause of 2□ No
Viita	certifica rector, p	Be	25. Was case referred to medical examiner?	ospital:						eath (Check only			
of	ding Phyaician: n. After this certific funeral director,	n: To	27. Manner of Death	28a. Date of Inj	iury	ER/Outpatient 28b. Time of		c. Injury	4 Nursing	Home 5 Res 28d. Describe			n hospice
sior	Attending P death. ctor: After t y the funera	catio	1 Natural 5 Pending 2 Accident investigation	(Month, D	ay rear)	Injury	M		s 2□No				
Division of Vital Records,	if or Atteno after death Director: Jin by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At ho atc. <i>(Specif</i> y	me, farm, stre	et, factory,	office		28f. Location City or To	(Street and No own, State)	umber or Rura	al Route Number,
_	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by		29a. Certifier 1— Certifying Phys	icien: To the bes	t of my know	wledge, death	occurred a	t the time	, date and pla	ce, and due to the	cause(s) and	manner as s	tated.
	tha H hin 24 tha Fu	Medicai	one)	er: On the basis and manner s	of examinat	tion and/or invi	estigation, i	n my opi	nion, death oc	curred at the time	, date and pla	ce, and due to	the cause(s)
	5 2 2 2		29b. Signature and tyle of certifier	\ \			290.	License	number SELI		29d. Date si	gned (Month,	Day, Year)
	M		30. Name and address of person who con	npeted cause of	death (Item	23а) (Туре, Р	rint)	40	5)-1			1	
		- 1	DCV: D RIS-Q	erg 3) <	ST PC	iul	Pi	Bal	Limore	nd	. 21	202
*Y.	Stat Registra		APR 1 3 20	05 See	uar s signal	# Ap	ede						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUD 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Braboy Garnetta 2005 4 9 4:45a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NA Baltimore Future Care Homewood 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1-14-19 5. Social Security Number **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🛛 F 011-24-2825 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland it Hygiene.
other than "natural", or Itama 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 XYes 2 □ No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA or itama 23a 1814 E. Lanvale Street 21213 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. other traumatic event, the Medical Exercine 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th grade 17. Father's Name (First, Middle, Last) Domestic Other People Homes Maryland Pages 1 and 2 should be fill ment of Health and Mental Heart: If itam 27 is marked offillery or other traumatic evan 18. Mother's Name (First, Middle, Maiden Sumame) Ford Mary Charles Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7006 Sycamore Ave., Takoma Park, Md. 20912 Beatrice Putnam Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Substitute 1 Su permit. Page Department o Important: If any injury or once. Mt. Carmel Cem. 4-14-05 Dundalk, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore Md 21202 Tuesor March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): ACCIDENT /Medical **Examiner** Hypertersion Sequentially list conditions, if any, leading to immediate class (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year

this

Division of Vital Records, P.O. Box 68760,

Physician/Medical þ Completed 2 Certification;

23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown 9 Unknown

5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an autopsy performed. Yes 2 No 1 🗌 Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo 27. Manner of Death 1 Denatural

2 Accident

3 Suicide

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

23e. Did tobacco use contribute to the cause of death?

Daliced Saluc Mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOGS 9056

Beit MO

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

29b. Signature and title of certifier

west MT Royal Aug 32. Registrar's Senature

within 24 hours a To the Funeral D To the Hospital

VOID

CERTIFICATE

05-12475

SEE

CERTIFICATE #

05-04494

			1 - State of Maryland / Dep State Registrer State of Maryland / Dep	artment of Health and M rtificate of Death	ental Hygie	2000 17470
	Physici	an	1. Decedent's Name (First, Middle, Last)			Day Year 3. Time of Death
	/Medic Examir	al	Louis E. Borowski 4a. Facility Name (If not institution, give street and number) BAYVIEW MEDICAL CENTER	4b. City, Town, or Location of Death BALTIMORE CITY	APRIL	10, 2005 3:25a M 4c. County of Death n/a
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 80 Yrs. last birthday.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month Day Ye	9. Birthplace (State or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	r 28a-f show	ţō	Md n/a Ba	altimore		1 ⊠Yes 2 No
	or 28	Sire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	s 23a	rail	2541 Fait Ave.	21224	- West and No.	USA 14. Race - American Indian,
920	72 hours after death with the Maryland natural', or items 23a or 28a-f show Jisal Examilier Fust be indified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 3 Never Married 2 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 2 Never Married 3 Never Married 4 Never Married 3 Never Married 4 Never Married 4 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 5 Never Married 6 Never Married 5 Never Married 6 Never Married 6 Never Married 6 Never Married 7 Never Married 7 Never Married 7 Never Married 7 Never Married 7 Never Married 7 Never Married 7 Never Married 7 Never Married 7 Never Married 8 Nev	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White, etc. Specify: White
5-0	72 hour natural	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv.	dent's Usual Occupation a kind of work done during most of workin DO NOT use retired)	ng 16b	. Kind of Business/Industry
21215-0036	⊆ 2	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) treet Cleaner	į.	ty of Baltimore
2	e tiled withi al Hygiene. other than vent, ille M	ပိ	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	
an	b d la b	To Be	Michael Borowski	Anne	Borows	ski
ary	s 1 and 2 should of Health and Men item 27 is marke other traumatic	V 4	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rura	l Route Number, Ci	ty or Town, State, Zip Code)
Σ	1 and 2 Health a tem 27 is			S. Potomac St.		
Baltimore, Maryland	if ite		1 M Burial 2 U Cremation 3 U Hemoval from State C	matory or other place)		Location - City or Town, State
Ē	permit. Pages Department of Important: if it any injury or o	1	· Countries of Control (Copensy)	anislaus 4/15 AvrorowskifaTuner		
Ba	Depa Impo any i		· / / / / / / / / / / / / / / / / / / /	201 Dundalk Ave.		
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List got one cause on each line. Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac o		Chisot and Doath
	/Medical Examiner		bue to (or as a consequence of):	zirus xieigire (ai	WIOAKZON.	i disase
	ed sit	Examiner	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury			
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9	iticate g physi as the l		d.			
P.O. Box	The law requires that the death certiticate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transi	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	equires that sen signed b tould be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?
of Vital Records,		Completed			24a. Was an autopsy performed	
/iita	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
of	Phys this al di	<u>۲</u>	1 X Yes 2 □ No Hospital: 1 □ Inpatient ☐ FVOutpatie 27. Manner of Death 28a. Date of Injury 28b. Time 6		me 5 Residence 28d. Describe how in	e 6 □Other (Specify)
on	ding h. Atter	tion	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	zod. Describe now i	njury occurred
Division	al or Attending s atter death. il Director: Attend in by the tune	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)		28f. Location (Stree City or Town, S	t and Number or Rural Route Number, fate)
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, dea **Medical Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2.	M	29b. Signature and title of certifier	29c. License number OCME		Date signed (Month, Day, Year) PRIL 10, 2005
11	+1/		30 Name and address of person who completed cause of death (Item 23a) (Type	Print) 111 Penn Stree		more, Maryland 21201
V	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Regionar's Signature APR 1 3 2005	Roadh D		
	riegist	A T.I.	HEK I D LUUD REGION A			

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ĭ1, Vera Bidniuk 2005 April 9:15 p^M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 108 Gothard Road Lutherville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North Days | Hours | Min. | 8 / Months | Max | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | North Day | 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🖾 F Ukraine 76 218-36-2088 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f shov other traumatic event, it a Modical Examin at must be recitied at 28a-f show 1X Yes 2 □ No Directo Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 2604 Fleet Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home Pages 1 and 2 should be filed nent of Health and Mental Hyginant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kowalinko unknown Melpfody Puzanenko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Gothard Road Lutherville, Md. 21093 Mrs. Ana Straw/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite any injury or of once. 1 Burial 2 □ Cremation 3 □ Removal from State 4/16/05 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus 21. Signature of Funeral Service Lice KarzorowskiriFuneral Home P.A. 1201 Dundalk Ave. Baltimore, Md. calq. 23a. Part1. Enter the disease, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Years Immediate Cause (Final **Physician** CORONARY ARTERY DISEASE /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No for Month Day 5 Other (specify) P.O. law requires that the as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No HYPERTENSION autopsy performed r this certificate har 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other 4 Nursing Home 5 Residence 6 Sother Specify S Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🐼 No 28a. Date of Injury (Month, Day Year) Hospital or Attending Pt
 24 hours after death.
 Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending M 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral D 1 CCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) April 12, 2005 D-18151

DHMH 17 Rev 1/2001

Registrar

301 St. Paul Place #409 Balto., Md. 21202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2005

32. Registra s Signature

Chi-Shiang Chen,

31. Date filed (Month, Day, Year) APR 13

			1 - For State Registrar	State of Maryland	-		of He		-		2005	121	÷ 78
	Physic	ian	Decedent's Name (First, Middle, Last) DANTE		D	EL TNC	VTV		2. Date of De		^y 2005 ^{Year}	3. Time of	
100	- /Medi	cal	DAVID 4a. Facility Name (If not institution, give st	root and number)	В	EL INS		Location of Death	1			5:05	Рм
	Exami	ner	12 RUSHVINE COURT			40. Спу, 1	rown, or i	OWINGS		40	. County of Deat R ∆	r LTIMORE	=
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under		If Under 24 Hrs.	8. Date of Bir	th .		hplace (State ountry)	
	Director		220-35 - 6966 1X	M 2□F 83	Yrs.	Months	Days	Hours Min.	DEC.2,	1921	Co	UKRA	INE
	and		Usual Residence of Decedent 10a. State 10b. County	10c, City.	Town or Lo	cation						10d. Inside C	ity Limite
	Maryl f sho	ō	MD BALTIM			GS MII	211					1 🗆 Yes	•
	r 28e	irec	10e. Street and Number	IOILE	ONTIN	10f. Zip (10g. Cit	izen of What Co		
	th with	by Funeral Director	12 RUSHVINE COURT	•				21117				USA	
	ems erm	Iner	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	. 13. V	Vas Decede	ent of His	panic Origin? (S , Mexican, Puerto	pecify Yes or No	-	14. Race - Ame Black, White		
36	s afte	y F.	1 ☐ Never Married 2000 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X		I□Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,	ŀ	Specify:		
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-1 show disal Everificer must be rodified at	ed b	15. Decedent's Educa	Year or Dates:	16a. Deced	lent's Henal	Occupat	ion		16b K	ind of Business/	WHITE	•
215	nin 72 In "na Medis	plet	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work	k done du	iring most of wor	king	100. K	ind of business/	industry	
21	filed within Hygiene. Ither than "	Completed	5+	Conege (1-401 5+)	VICE	PRES:	I DEN	T		CON	STRUCTI	ON	
nd	be file tal Hy d oth avant	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle	Maiden	Surname)		
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-1 show or other traumatic avant. If a Mardical Exercites must be notified at	2	MOISEY		ELINS			NINA				SCHNE	ER
Ma	d 2 sho th and th sma 17 is ma traum		19a. Informant's Name/Relationship (Type ANNA BELINSKAYA /					nd Number or Ru					
ē,	tand Health tem 27 other tr		20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name	e of	OURT - O	Date		cation - City or		
ğ	Pages ent of nt: If i		1 Burial 2 Cremation 3 Re. 1 Donation 5 Other (Specify)	moval from State	netery, cren TM∩DF	-		em. 04/12	/2005		I STERST		1
Baltimore	permit. Pages 1 a Department of Hea Important: If item any injury or othe once.		21. Signature of Funeral Service Licenses			Name and					& BROS.		
m	Depa Impo any i		Dieth Mil	utten	8	900 RI	EIST	ERSTOWN					208
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death.	Do not ente	er the mode	of dying,	such as cardiac	or respiratory a	rest,		Approximate Interval Bets	a ween
-	Pnysician		Immediate Cause (Final disease or condition	Due to (or as a conseque	irato	ry f	ailu	NP				Onset and I	-
	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):		,	0 1				,	
		<u>_</u>	Sequentially list conditions, b.					· failu			-	onehoi	1/
W	uted d ansit	Examiner	Sequentially list conditions, if any, Learns to in mediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	10 Sol N	ioi	crr	Losis				2 we	eks
o, c	be executed sician and burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a conseque	nce of):			A				5426	
8760	ate be nysicia he bu	ical	d.	End!	stage	. ire	nat	failu	ie			3 42 h	15
39)	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:						-				
Вох	ath catternation of the satternation of the sa	ian/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de	eath 3 🗆	Ectopic pre					23d. Date of delin		ear ear
P.O.	that the de led by the a detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of deat 9□ Unknown	th 5∐	Other (spec	cify)					,	
٣.	res that I igned by be deta		Part II. Other significant conditions contr	ibuting to death but not resulti	ing in the un	derlying cau	use given	in Part I.	23e. Did to	bacco u	se contribute to	the cause of d	eath?
rds	quires nn sigr uld be	ed by							1 🗆 1	'es 2	□No 3□Pro	bably 4 XU	Inknown
000	aw requir s been si 2 should b	plete							24a. Was		24b. Were aut	opsy findings a	available
performent? death?								luse of					
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Place of Deat		-	12,00		
of V	Physician: this certifici ral director,	မ	1 ☐ Yes 2 No		NOutpatient			4 Nursing Ho			6 □Other (Spec	ify)	
	ing After une	Certification:	27. Manper of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury		c. Injury a Work?		28d. Describe h	iow injur	y occurred		
Division	deatl deatl ctor: / the	fical	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	e farm stre	M et factory		s 2 No	28f. Location /5	itreet an	d Number or Rur	al Boute Numb	hor
Ö	F e F C	erti	4 Homicide determined	building, etc. (Specify)	0, 14111, 000	ot, ractory,	011100		City or Tov	n, State)	ar ribute rvuiri.	761,
	To the Hospital of within 24 hours at To the Funeral D completely filled in		29a. Certifier 1 Certifying Physic	ian: To the best of my knowle	edge, death	occurred at	the time	, date and place,	and due to the	ause(s)	and manner as:	stated.	- 10
	To the H within 24 To the Fi complete	ledical	31.07	r: On the basis of examination and manner stated.									
•	To COLT	Σ	29b. Signature and title of certifier	W. imp		29c.	License r	number		29d. Dat	e signed (Month,	Day, Year)	
	M			Knj m.D.		V	1	10)6		4	111196		
	29b. Signature and title of certifier 29c. License number D 2 9 0 3 6 30. Name and address of person who completed se of death (Item 23a) (Type, Print) BELVEDERE AVE. BASTIMORE, MD State 31. Date filed (Month, Day, Year) 32. Registrat's Signature												
100	Sta	te	31. Date filed (Month, Day, Year)	32. Registra 's Signatur	9	طر	f. +				010	1.2	
	Registr		APR 13	32. Registra's Signatur	M	- TON							

			1- For State of M	Maryland / Depa	artment of F			iene 05	12479
	Physic		1. Decedent's Name (First, Middle, Last)	X			2. Date of Deat Month	Day Yea	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and number	r)	4b. City, Town, or	Location of Death	5	4c. County of De	
	Funeral Director		219-26-7789	Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MAR 2,	Year) 9. B	irithplace (State or Foreign Country) aryland
	ehow	2	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ith the Maryla or 28a-f ehor	Director	Florida Duval 10e. Street and Number		Jackson	ville	10	Og. Citizen of What (
	th with 23a or	al Di	8787 Southside Blvd.			256		USA	oounity.
036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or iteme 23a or 28a-f ehow event, the Masteal Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceder Amed Force; 1 Yes, 20; 1 Yes, 3ve Year or Dates	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Ispanic Origin? (Spe in, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours to f Health and Mental Hygiene. If tiem 27 ie marked other than "natural; or other traumatic event, Ite Macked Ex.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40	(Give life.		ation during most of workir)	ng 1	16b. Kind of Busines	,
9	filed the Hygie other lent, IL	Be Co	17. Father's Name (First, Middle, Last)	Erect	trician	18. Mother's Name	(First, Middle, M		Industry
ırylan	thould be id Mental marked matic ev	To B	Fletcher James Cox 19a. Informant's Name/Relationship (Type, Print)	19h Mailie	ng Addross /Street	Gerti	rude Mel	va Middle	
e, Ma	l and 2 s lealth ar im 27 ie her trau		Mary Catharine Cox-Raynor	daughter 1	1206 Valle	ey Road 1	Pasadena	, MD 2112	.2
Baltimore,	Pa Intrin		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from Stat '4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crer Metro Cre	natory or other plac	e)		oc. Location - City o	
Ball	permit. Departrimports any inju		21. Signature of Funeral Service Licensee Dawn F McDonald	220	Name and Address Cremation 299 Freder	Society o	of Maryl Baltim	and, Inc.	1228
	Physician /Medical Examiner	_	1.1	ad the death. Do not ent ine. S S a consequence of):	er the mode of dying	g, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death Cays
8760,	icate be executed physician and sthe burial-transit	dicai Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events c	s a consequence of):	5				years
P.O. Box 6	Attending Physician: The law requires that the death certific reads. result. ector: After this certificate has been signed by the attending toy the funerat director, page 2 should be detached for use as	by Physician/Me		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
ords, F	w requires that been signed should be det	ed by P	Part II. Other significant conditions contributing to death Relications Contributing to death	but not resulting in the ur	nderlying cause give	on in Part I.	23e. Did toba		to the cause of death?
Vital Records,	ysician: The law r is certificate has be director, page 2 sh	Completed	\				24a. Was an autopsy perform	prior to	utopsy findings available comptetion of cause of s 22 No
Z;	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 446 Hospital: 1 446pat	ent 2 ☐ ER/Outpatieni	t 3 DOA Othe	26. Place of Death			
Division of	ending Phy ath. or: After this		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Inj (Month, D		28c. Injury Work	4 Nursing nom	e 5 Hesiden Bd. Describe how	ce 6 □Other (Spe v injury occurred	acify)
Divis	s after de al Directo ad in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Ir building, e	jury - At home, farm, stre tc. (Specify)	eet, factory, office	28	3f. Location (Stre City or Town,	et and Number or R State)	dural Route Number,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the besis and manner s	of examination and/or inv	occurred at the time restigation, in my op	e, date and place, ar inion, death occurred	nd due to the cau d at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier May 7 + Sha	all	29c. License	number 533 (9 /	d. Date signed (Mon	th, Day, Year)
-			30. Name and address of person who completed cause of NAUCY F. SWOW	death (Item 23a) (Type, F AA NA	2:0	11-6		1-1-0)
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 2005	rar's Signature	9				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Harold Conley, Jr. John 12:46 AM 2005 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROSEDALE FRANKLIN SQUARE HOSPITAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month Bay, May 13, 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1**X**□M 2□F 80 DF. Director 143-16-4948 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "neturel", or Items 23e or 28a-f show treumatic event, the Medical Examination motified at 10d. Inside City Limits MD Baltimore Parkville Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Boulevard by Funerai 21234 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 3 Widowed 4 □ Divorced Specify: White WWTT Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be tiled within 72.
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "ne any injury or other treumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Insurance Broker Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Harold Conley, Sr. Lucille (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John S. Ramming (Step-son) 2219 Tufton Ridge Road Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Springfield Cemetery 4/15/2005 Sykesville, MD 21. Signature of Funeral Service Licensee ĤAIGHT FUNERAT HOME & Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ardiomyo disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque Examiner nding physician and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy Year Month Dav 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s autopsy performed? (es 2 100 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☐ No 2 FER/Outpatient 1 🗀 Inpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Atter 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident tilled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the i 29b. Signature and title of centilier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, My' -Bully 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end item#4c, perFH, g842, 4-13-05 TT State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Oate of Death 3. Time of Death APRIL 1th 2005 **Physician** THELMA PRIDGN CLARK 4:01 AM /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** RUXTON HEALTH & REHABILITATION PIKESVILLE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 🔀 F 90 217-20-7954 Director 01/27/1915 NORTH CAROLINA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show ust be notified at BALTIMORE 1 ☐ Yes 3 ☐ No Director MD PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 SUDBROOK LANE 21208 **23a** USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14, Race - American Indian. 11. Marital Status other treumatic event, the Mudical Examinative Black, White, etc. 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Specify: BLACK þ 3€Widowed 4 □ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7TH DRY CLEANERS HARFORD CLEANERS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be finand Mental H MARCELLUS SPEIGHT INEZ ပ MOYE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl Department of Health an Important: If item 27 Is r any injury or other treur 2002. 8425 HARBOR STATION WAY, JANETTA SMITH / DAUGHTER PARKVILLE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 Other (Specify) ARBUTUS MEM. PK. 4/16/05 BALTIMORE, MD Funeral Service Licensee 21. Signatul 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 the Enter the disease, or complications that caused the death ock, or least follure. List only one cause on each line. 4600 LIBERTY HGHTS. AVE., BALTIMORE, MD To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease of condition resulting in death) **Physician** ect mt /Medical Due to (or as a consequence of): **Examiner** Mooke Left Knee Amputation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit PSIS Due to (or as a consequence of) Box 68760. attending physician certificate be O CCINSINE eswer by Physician/Medical disesse EXTECH the enes IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🕱 No P.0. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, DIABETIC mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed2 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this uneral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. investigation 1 Yes 2 No within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 030115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hiukpehai,mo 2600 L 15esty HaTS 31. Date filed (Month, Day, Year) Registrar's Signature 32. State APR 1 3 2005 Registrar

			A SAME	epartment of Health and Menta Certificate of Death	Hygiene	82
1	Physici	an	Decedent's Name (First, Middle, Last)	2. Date Mor	of Death Thy Day Year 3. Time of	Death
	/Media	cal	William Confee	0	4 11 2005 210)5 M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Baltimore	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs. 8 Date	N/A of Birth Birthplace (State of	r Foreign
	Director		219-18-7251 12X 2□F 78 Yr	s. Months Days Hours Min. 100	22/1926 MARYLAND)
	ow ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	or Location	10d. Inside Cit	ty Limits
	B-fsh	tor	MD N/A BAL	rimore	1 X Yes	2 □ No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
	s 23e	erai	6905 BRIGHTWAY PLACE	21207	USA	
(0	rs after death with the Marylar , or Itams 23a or 28e-f show	Funeral Director	11. Marital Status 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married	 Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 	s or No- tc.) 14. Race - American Indian, Black, White, etc.	
903	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show lical Exacil at must be multicd at	þ	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	Specify: BLACK	
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212	J within 7 piene. r than "n	ошо	Elementary/Secondary (0-12) College (1-4or 5+) 1 2 TH 4 YEARS	fe. DO NOT use retired) PAROLE DEPT.	STATE OFMARYLA	NID
nd ;	filed Hyg otha	Bec		18. Mother's Name (First,		ND
yla	should be nd Mental nmarked c	2	WILLIAM G. CONTEE, SR.	EMMA PAYNE		
Maryland 21215-0036	d 2 tha 7 is	8	19a. Informant's Name/Relationship (Type, Print) Carole C. Stinson / DAUGHTER	Mailing Address (Street and Number or Rural Route	Number, City or Town, State, Zip Code) 78	664
	s 1 and f Health Itam 27 other tr		20a. Method of Disposition 20b. Place of D	907 FIELDSTONE PL	ROUND ROCK, TX 20c. Location - City or Town, State	
OE .	0 0			crematory or other place) US MEM. PK. 4/16/05	BALTIMORE, MD	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Uneral Service Licensee	22. Name and Address of Facility HOWELL	FUNERAL HOME 2120	07
	<u>0</u> 0 = € 0		23a. Pall Enter the disease, or complications that caused the death. Do not	4600 LIBERTY HGHTS		
			strock, heart faflure. List only one cause on each line.	enter the mode or dying, such as cardiac or respira	ttory arrest, Approximate Interval Betwood Onset and D	veen
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R	Examiner		Sequentially list conditions b. COYONAYY	THERY DISEASE		
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Вох	death certific e attending p d for use as f	cian	23b. Was decedent pregnant in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Y	ear
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S, D	The law requires that the de ate has been signed by the a page 2 should be detached f		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e	. Did tobacco use contribute to the cause of de	ath?
ord	w requir been si should	eted	DIADETES MULTUS 14 DE 1		1 Yes 2 No 3 Probably 4 U	nknown
Records,	hasb ge2s	Completed by		24a	. Was an autopsy performed? 24b. Were autopsy findings a prior to completion of ca death?	variable use of
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Division of Vital	Attanding Physician: r death. sector: After this certifica by the funeral director, I	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	26. Place of Death (Check	Residence 6 Other (Specify)	
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SIO	ottand death ctor: / the f	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm	M 1 Yes 2 No	tion /Street and Mumber or Dural Deute Numb	
≥	al or a safter l Dira d in by	Certification:	4 Homicide determined 228. Place or injury - At home, farm building, etc. (Specify)		tion (Street and Number or Rural Route Numb or Town, State)	er,
	Hospital or Attanding I 4 hours after death. Funaral Diractor: After tely filled in by the funer	edical (29a. Certifier (Check only (Check only and Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place, and due	o the cause(s) and manner as stated.	
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medi	one) and manner stated. 29b. Signature and title of certifier			
1	T W T Q		Vanda alana - 117	29c. License number	29d. Date signed (Month, Day, Year)	
	11		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	1 / PM 11, 2005	
	1,		Cambeen F Brennan MD 22 Sm	th Greene Street Bulh	more, MD 21201	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	Sneeds >		
	- riegiotii		APR 1 3 2005 Regue &			

		1 - For Amend Item 2	3a per Dr.		riment of H 3/05dhb tilicate of L	lealth and Death	Mental Hyg	iene g. No 0 0	5 12	1.83
Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month		ear	ne of Death
/Medic		Jose Castro					March 3		10:	01 PMM
Examin	er	4a. Facility Name (If not institution, give	Adventist]	Hoenital	4b. City, Town, or Takoma		ath	4c. County of Montgo		
Funeral		5. Social Security Number unk 6. Se		In yrs. last birthday)	If Under 1 Year	If Under 24 Hi	rs. 8. Date of Birth	_	. Birthplace (Sta	ate or Foreian
Director		11	XM 2□F 29	Yrs.	Months Days	Hours Mi	s. 8. Date of Birth (Month, Day, Nov 18,	1875	Country) Mexico	
ital Hygiene. d othar than "natural", or Itams 23a or 28a-f show evant. The Medical Examinet must be notified at		Usual Residence of Decedent 10a. State unk 10b. County	unle 1	0c. City, Town or Lo	ation				n1- 404 I	- 02 11 2
Department of neathr and Mental Hygiene. Department of neathr and Mental Hygiene. By injury or other traumatic event, the Medical Examiner must be notified at once.	٥	Tob. State UTIK Tob. County	ulik	oc. Ony, rown or go	allon			u	nk 10d Insid unk	Yes 2 ☐ No
28a-	Director	10e. Street and Number		un	10f. Zip Code		unk 10	Og. Citizen of Wha		
3a or				dii			ulik	•	,	unk
ar mu	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.unk 13. y	Vas Decedent of Hi	ispanic Origin? ((Specify Yes or No-		American India	n,
or di	y Fu	1 X Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ No If Yes, Give		X Yes 2□ No	Specify: Me			White, etc. White	
SI EX	ed by	3 Widowed 4 Divorced	Year or Dates:	1.40- 0						
dia.	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	ent's Usual Occupa kind of work done of ONOT use retired	during most of w	orking unk	16b. Kind of Busir	ness/Industry	unk
The Park	omi	Elementary/Secondary (0-12) unk u	College (1-4or 5+) Ink			,				
vant,	Bec	17. Father's Name (First, Middle, Last)			unk	18. Mother's Na	ame (First, Middle, M	Maiden Sumame)		unk
atic e	To									
raum		19a. Informant's Name/Relationship (T	•				Rural Route Number,	,		
thar t		Washington Advent 20a. Method of Disposition		20b. Place of Dispos		Avenue '	Takoma Par		20912	
0.0		1 Burial 2 Cremation 3	Removal from State	cemetery, cren	atory or other place	θ)	Date	20c. Location - Cit	y or rown, State	в
injury t		* 4 □ Donation 5 ☒ Other (Specify)		-22	Name and Address	s of Facility				
any ir		21. Signature Ronal Service Licent	Wade, Direc	.////	ate Anato 1timore,		d 655 W.	Baltimor	e Stree	t
		23a. Parti. Enter the disease, or comp	lications that caused the	e death. Do not ente	r the mode of dying	g, such as cardi		est,	Approxi	mate
ian :		Immediate Cause (Final	ne cause on each line.	000	alead				Onset a	Between and Death
ical		disease or condition resulting in death)	aDue to (or as a co	onsequence of):	Grad					W
ner'		Sequentially list conditions,	. Her	attl'	fail	wel			20	aus
	Iner	cause. Enter Underlying		unsequence of):						C
<u> </u>	Examln	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co							
s me bunal-transit	dlcalE									
as the	edlo		0							-
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐	oregnancy				23d. Date o	f delivery	
	slcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tim		Ectopic pregnancy Other (specify)			Month	Day	Year
	Phys	9 Unknown								
en eg	by	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the un	derlying cause give	en in Part I.		acco use contribu		
should	Completed	Account of	wase				1 L Ye	s 2 [] No 3 [Unknown
N	mple						24a. Was an autopsy perform	/ prio	e autopsy findir r to completion	ngs available of cause of
ector, page									Yes 20 Ho	
irector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 40	Hospital:	2 T F B / O - + + + + + + - +	2CT DOA Othe	VC-	eath (Check only one			
eral di	\vdash	27. Manner of Death	1 Hipatient 28a. Date of Injury	2 ER/Outpatient	28c. Injury	at at	Home 5 Resider		Specity)	
the tuner	atlo	1 → Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Injury	Work M 1 □ Y	:? ∕es 2 □ No				
5	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, stre	et, factory, office		28f. Location (Str. City or Town,		or Rural Route N	Number,
E D0	Cer		building, etc. (c				Only of Yours,	State/		
tely filled in by the	ical	Check only 2 Medical Exam	sician: To the best of miner: On the basis of exa	amination and/or inv	occurred at the timestigation, in my op	e, date and place	e, and due to the ca	use(s) and manne	er as stated.	se(s)
completely filled in	Medical	29b. Signature and title of certifier	and manner stated		29c. License					
8		Dal all all all	21 1		290. License	L> 0 1	29	d. Date signed (A	10 - Yea	u)
		20 Name and address of access with	ompleted cause of death	b >	D GO	1001		3/31	105	
		· 1 / .		(Item 23a) (Type, F	LO Am	Ja I om	e Park	MA >0	912	
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's		- 100	1-00	a ruce			
Registra		APR 1 3 2005 A	Golden D.	14 marie						

			1 - For State Registrar	State of Maryla	ınd / Depa			Mental Hyg	iene 19. No.2 () ()	5 12484
4	Physic /Medi	cal	Decedent's Name (First, Middle, Last,	<u> </u>	١.	COHEN		A PC: 1	10 200	
<i>f</i>	Exami Funeral		4a. Facility Name (If not institution, give UNION MEMORIAL 5. Social Security Number 6. Se	HOSPITAL 7. Age (In yr	s. last birthday)	If Under 1 Year		MORE	4c. County of	N/A Birthplace (State or Foreign Country)
	Director		216-01-5863 1X Usual Residence of Decedent 10a. State 10b. County		39 Yrs. Dity, Town or Lo		3 110013 18411.	8. Date of Birth (Month, Day, FEB. 14,	1916	MD 10d. Inside City Limits
	h the Mary or 28a-f sh	irector	MD BALT 10e. Street and Number	IMORE	BAL	TIMORE 10f. Zip Code		10	g. Citizen of Wha	1 Tyes 2 No
' 0	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at	Funeral Director	3104 NORTHBROOK 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of Yes, specify Cu	21208 f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		USA American Indian, White, etc.
215-0036	72 hours after dea "natural", or Items	Completed by	3 ☑ Widowed 4 □ Divorced 15. Decedent's Edu (Specify only highest grad	cation	MY 16a, Deced	lent's Usual Occi		rking	Specify: 6b. Kind of Busin	WHITE
7	filed within Hyglene. other than " ent, the Me.	e Compi	Elementary/Secondary (0-12) 5 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		KER	7	me (First, Middle, M	FINANCI	AL
Maryland	2 should be and Mental Is marked o	To Be	MENDEL 19a. Informant's Name/Relationship (Ty	pe, Print)	COH		MIRIAI et and Number or Ri	М		WEINBERG
_	Pages 1 and 2 nent of Health a int: If item 27 ly iry or other tra		JEFFREY I. COHE 20a. Method of Disposition 1 X Burial 2 Cremation 3 CP	20b.		6 WILLIS sition (Name of natory or other pi		_	SPRING,	MD 20905 y or Town, State
Baltimore	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		4 ☐ Donation 6 ☐ Other (Specify) 21. Signature Funeral Service Licenters	BA	22	HEBREW	ress of Facility	12/2005 SOL LEVIN	SON & BR	
	ate be executed Medical hysician and the burial-transit the burial-transit The bur	ilcal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of shock, or heart failure. List only of listed cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leadin, to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	or the mode of dy	ying, such as cardia esse	c or respiratory arre	st,	LE, MD 21208 Approximate Interval Between Onset and Death
P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 🗆	Ectopic pregnan Other (specify)	су		23d. Date of Month	f delivery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significent conditions cor	tributing to death but not re	esulting in the un	derlying cause g	rven in Part I.			te to the cause of death? Probably 4 🗹 Unknown
<u> </u>	The ate h page	Completed						24a. Was an autopsy perform	ed? prior	
o	Attending Physician: The death. ector: After this certificate by the funeral director, pages	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 🗷 Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	ther: 4 🗆 Nursing H	ome 5 Resider 28d. Describe how	ice 6 Other (Specify)
Division	tal or Attendi s after death. al Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (Stre City or Town,		r Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	one)	ician: To the best of my kr ler: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the estigation, in my	time, date and place opinion, death occu	, and due to the cau	ise(s) and manne e and place, and	r as stated. due to the cause(s)
	vithin 2 To the complete	M	29b. Signature and title of certifier			AT2	138946 -		d. Date signed (M	onth, Day, Year)
	7)		30. Name and address of person who co Ali Esmaili Union Y 31. Date filed (Month, Day, Year)	mpleted cause of death (Ite Nexworiw) Hose 32. Registrar's Sign	ital 201	East 1	University 1	Parkway E	Bultimore	, MD 21218
	Sta Registr		on Jako mod (Month, Day, 1941)	2005	N.	beile				

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ORIGINAL

		For State Registrar	State of	Marylar	•	artmen rtificat			and Mo		giene Reg. No.		12485
Physicia		1. Decedent's Name (First, Middle,	Last)	D.						2. Date of De. Month	Dav	Year	3. Time of Death
/Medic	al	Willie	-i		ıncan	4h Cihr	Tour	Location of	of Doath	4		005 inty of Death	6:30p M
Examin	er	4a. Facility Name (If not institution, 6155 Radeck)		Hell)			ltim		Deam		40. 000	NA	'
Funeral Director		5. Social Security Number 053–44–5948	6. Sex 7. 1X M 2 ☐ F	. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 4–10-	h y, Year) -51	9. Birth	place (State or Foreign intry) N.Y.
pug *		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
Maryli f sho	ō	Md. NA			Bal	timor	·e						Y□Yes 2□No
r 286-	rect	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	intry?
th with	aiD	6155 Radecke A	venue			2	1206				1	USA	
within 72 hours after death with the Maryland jien. Than "nature!", or items 23a or 28e-f show the Madical Exeminer must be notified at the Madical Exeminer must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced Armed Force 1 Yes 2 If Yes, Give Year or Date	es? No	ì	Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Spec i, Puerto F	cify Yes or No Rican, etc.)	8	Race - Ameri Black, White ecify: BI	
72 ho	Completed	15. Decedent' (Specify only highes	s Education grade completed)		16a. Dece	kind of wo	rk done c	lurina mos	t of workin	ng .	16b. Kind o	f Business/Ir	ndustry
within ene. than "	mpl	Elementary/Secondary (0-12)	College (1-4	lor 5+)	1	ck Dr			eW 5	sto	B=1+:	imore	City
illed v Hygie other t		12th grade 17. Father's Name (First, Middle, L	ast)		ILU	CK DL	Iver			(First, Middle,			CILY
• 6 a a	To Be	Bruce		Dunca			(2)	Не	elen	Route Numbe		Joyne	
1 m 1 m		19a. Informant's Name/Relationsh Maggie Duncan	Wi	fe						ltimore		2120	
1 and Health tem 27 other tr		20a. Method of Disposition		20b. l	Place of Dispo	sition (Nan	ne of	-)	Di	ate	20c. Locatio	on - City or T	own, State
nent of Int: If it		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		ate	cemetery, crei King Me		_ `	9) ; 	4-12	-05	Randa	allstc	own, Md.
Definit. Fages I all Department of Heal important: If item 2 any injury or other once.		21. Signature of Funeral Service L	-	2		. Name an March			•	Balt 1101	imore, E. Nor	, Md.	21202 e.
par icia	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consec									
attending p for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta nt at time of o	al death 3[Ectopic pr						Date of deliv Month	very Day Year
signed by the aid be detached	þ	Part II. Other significant conditio	ns contributing to dea	th but not re	sulting in the u	nderlying c	ause give	en in Part I		_	obacco use c		the cause of death?
ate has been sig page 2 should b	Completed									24a. Was autor perio 1 Yes	an 24 osy rmed? 2 No	Ib. Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of
this certificate had director, page	Be (25. Was case referred to medical examiner?					2.00		of Death	(Check only o	ne)		
this or	ဋ	1 ☐ Yes 2 No			ER/Outpatier			4 190	rsing Hor		dence 6 🗀		ify)
r death. ector: After by the funer	ion	7. Manner of Death Natural 5 Pending		Day Year)	28b. Time o Injury	M	8c. Injury Work	rai ⟨? Yes 2		8d. Describe l	low injury occ	Julied	
after death Director: A I in by the f	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place o	f Injury - At h g, etc. <i>(Speci</i>	iome, farm, sti fy)					8f. Location (3 City or Tox	Street and Nu vn, State)	ımber or Rur	ral Route Number,
4 hours Funeral	Medical Ce		Physician: To the becaminer: On the bas	is of examina									
within 2 To the complet	Me	29b. Signature and title Contifier	110			290	License	number	9/1	4	29d. Date sig	ned (Month,	Day, Year)
15		30. Name and address of person		of death (Ite	m 23a) (Type,		L'	> > > > > > > > > > > > > > > > > > > >	V (
S.C.		31. Date filed (Month, Day, Year)	32 Rec	gistrar's Sign	ature	DUI	DO	7015		J(1)			
Sta Registr				ane a d	1. So	Bar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 8 per fb 8344 6-28-05 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Dorsey W. 9:15 PM James April 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death IA MediCAL CONTER BALTIMORE N/A SALtimore L 8. Date of Birth (Month Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 XM 2 □ F Days Hours Min. 52 Yrs Md Director 214-56-7699 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Importently, or Items 23a or 28e-1 show importent: If item 27 is marked other then "naturel", or Items 23a or 28e-1 show any njury or other treumetic event, the Medical Evantina must be multiple at 10d. Inside City Limits Director Baltimore 1X Yes 2 No Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. F 21206 4912 Crenshaw Ave. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: ð Specify: 3 ☐ Widowed 4 ☑ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Military 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dorsey, Sr. Armstella Shorev James မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 Armstella Dorsey 1737 N. Bradford St., Baltimore, Md. Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4-14-05 Owings Mills, Md. Garrison Forest Vet * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 l adys H wormer) 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Aspiration Pheumonic disease or condition resulting in death) week /Medical Due to (or as a consequence of): Examiner Stroke Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): as the burial-transit or Attanding Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: for use If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 No Division of Vital 1 Yes 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 27 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After ! 1 Accident Injury 5 Pending after death. investigation 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 P17657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REENC STREET BALTIMORE, MD 21201 CIM, 10NG Rebecca Manno 2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 3 2005 Registrar

				State of M	laryland	-	artment of h		Mental Hy	giene	April Com	1010
		1 Decedent's Nam	ne (First, Middle, La	etl		Ce	rtificate of	Death	2. Dete of De	Reg. No.	45	3. Time of Death
	Physician /Medical	1, Decedent's Nam	HENRY	si)			DILLON		april	9 2	Year	8:30 PM
j	Examiner			e street end number,)				Location of Deat	th 4c. County	of Death	
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	puel #	Usuel Residence of 10a. Stete	10b. County		10c. City,	Town or Le	ocation				1	0d. Inside City Limits
	the Marylen r 28a-f show	MD	ВА	LTIMORE		BAL	TIMORE					1 ☐ Yes 2 ☐ No
	or 28a-f	10e. Street end Nu	mber		L		10f. Zip Code			10g. Citizen of	What Coun	itry?
	23a c	8222 N	MAXINE CI	RCLE				21208				USA
020	72 hours after death with the Marylend naturel; or items 23a or 28s-f show lifest Examiner must be notified at sted by Funeral Director		ried 2 ∑ Married 4 □ Divorced	12. Was Decedent Armed Forces' 1 Yes 2 1 If Yes, Give Year or Dates:	? No	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	lispenic Origin? (5 an, Mexican, Puel Specify:	Specify Yes or No rto Rican, etc.)	Specif	ce - Americ ck, White, o	
5-0	"naturel".	(Soe	15. Decedent's Ed	ducation		16a. Dece	dent's Usual Occup	ation during most of we	orkina	16b. Kind of B	usiness/Inc	Justry
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ylaı	should be not Mente marked imprise of To E	JACOB				DILLO	N	JENN	ΙE			KASTAN
Maryland	C/ 0 % 2	1	ame/Relationship (•			ng Address (Street			-		
o,	1 end Health Bm 27 rther to	20a. Method of Dis	DILLON /	MILC	20b. Pla	ace of Dispo	2 MAXINE		- DALIII	20c. Location		
Baltimore,	Parities Parities	1 X Burial 2 4 ☐ Donation	☐ Cremation 3 ☐ 5 ☐ Other (Specif				HEBREW (4/11/05	REI:	STERS	TOWN, MD
Bal	permit. Pe Depertmen important any injury ance.	21. Signature of Fr	uneral Service Licer	Cuttle			8900 REIS		SOL LEVI N ROAD -			, INC. MD 21208
-1/2	Physician	23e. Pert1. Enter i shock, or hea	the diseese, or com art failure. List only	plications that cause one cause on each I	d the death. ine.	Do not en	ter the mode of dyir	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
-4	/Medical	Immediate Cause disease or condition	(Final	a. End-s	Lage	als	beenes!	s dise	ase		1	Tyeors
400	Examiner	resulting in death)		a		as a conse	quence of):					
6.3	nine and			b			· · · · · · · · · · · · · · · · · · ·				İ	
0,0	an end riel-trensit	Sequentially list co if eny, leading to in cause. Enter Under	onditions, nmediete erlying		Due to (or	es a conse	quence of):				i	
, 09289	icete be executed physician end s the buniel-trensit edical Examir	Cause (Disease or that initieted event resulting in death)	s injury	¢	Due to (or a	as a consec	uence of):					
Box (d							 	
	deeth cert le ettending ed for use g	Part II. Other signi	ficant conditions o	ontributing to death b	out not result	ting in the u	nderlying ceuse giv	ren in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
P.0	es that the deeth certigined by the ettending be deteched for use to by Physician/M								10	Yes 2 No	3 □ Prob	pabiy 4 ☐ Unknown
Records,	eeen s hould									an autopsy ormed?	ava	ere autopsy findings allable prior to appletion of cause
Rec	9 8 0								40	V 0.		deeth?
ta	certificate rector, pag	25. Was cese refer	red to medical					26 Place of De	aath (Check only	1414	1]Yes 2□ No
of Vital	Physician: rthis certific ral director, r. To Be (examiner?		Hospital: 1 Inpati	ent 2 E	R/Outpatie	nt 3 DOA Oth	or:	Home 5 ☐ Resi		er (Specify	()
	ding Phys th. After this funeral di	27. Mann of Deat 1	th 5 Pending investigation	28e. Date of Inju (Month, De		28b. Time o Injury	Wor	y et k? Yes 2 ☐ No	28d. Describe	how injury occur	red	
Division	tal or Attanding Pi rs efter deeth. al Director: After the led in by the funera Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of in	jury - At hon tc. <i>(Specify)</i>	ne, farm, st	reet, factory, office			Street and Numb wn, Stete)	er or Rure	Route Number,
	To the Hospital or Attanding Physician: The Is within 24 hours efter deeth. To the Funeral Director: After this certificete he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one)		ysician: To the best niner: On the basis o end manner st	of examination							
	Vithin To the comp	29b. Signature and		ac greg	es ord		29c. Licens			29d. Date signe		*
	10	30. Name end edd	ress of person who	completed cause of a	death (Item 2	23a) (Type,	Print) HA STRE	ET, BAL	TIFTORE			
2	State Registrar	31. Dete filed (Mon	th, Day, Yeer) APR	September 2003	Signatu	J. J.	Sperk	,				

DHMH 16 Rev 6/95

			1 - State Registrar		ryland / Depa <i>Ce</i> a	artment of H rtificate of L			giene 0 0	5	12488
ı	Physic		1. Decedent's Name <i>(First, Middle,</i> Vincent	Last)	Fle	ming		2. Date of Dea Month	Pay Y	/ear	3. Time of Death
7	/Medi Examir		4a. Facility Name (If not institution, Stella Maris M			4b. City, Town, or	Location of Deat	upne	4c. County of		0 "
	Funeral Director		5. Social Security Number 217–66–5601 Usual Residence of Decedent	. Sex 7. Age 1	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day 7-25-	7, Year) -58	Country)	e (State or Foreign) Md .
	aryland show	-	10a. State 10b. County	A	10c. City, Town or Lo Balti					10d.	Inside City Limits
	the M	Director	10e. Street and Number	IA .	Daiti	10f. Zip Code			l 0g. Citizen of Wh	at Country	Y Yes 2 No
	ath with	rai Di	205 N. Rose St			2122			USA		
036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-1 show he Mcdical Exament until by Invilled at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	,	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X1 No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Black, Specify:	American White, etc.	
9500-6121	n 72 ho "natur edical	leted	15. Decedent's (Specify only highest	Education grade completed)	16a. Deced	dent's Usual Occupa kind of work done d DO NOT use retired)	tion uring most of wo	king	16b. Kind of Busin	ness/Indust	try
N	be filed within 72 he tal Hygiene. d other than "naturesent, he Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+))	elf-Emplo			Arab		
and	uid be filed Aental Hygii rked other tic event, II	Be	17. Father's Name (First, Middle, La Ollie	st) H.	Fleming		18. Mother's Nar	ne (First, Middle,		ith	
ary	2 should be and Mental is marked eumetic ev	2	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a	nd Number or Ru	ral Route Number	, City or Town, St	ate, Zip Co	de)
ē, Z	1 and Health sm 27 ther tr	1	Ollie Fowlkes 20a. Method of Disposition	Sister	20b. Place of Dispo	9 Carlswo	T		or Mill, 20c. Location - Ci		21244 State
Saltimor	Pages ment of I sut: If its ury or o		1 ☐8urial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe	Removal from State	cemetery, crem King Me	natory`or other place	1		Randalls		
Dail	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Lic	, won	-e-	Name and Address March F.	H. East	Balt 1101	imoe, Md E. North	. 21	.202
	Frrysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or of shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a Due to (or as a of		er the mode of dying	, such as cardiac	or respiratory arro	est,	Inte	proximate erval Between iset and Death
,00/00	icate be exec physician an s the burial-tr	dicai	resulting in death) Last		consequence of):						
O DOX	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tin	Fetal death 3	Ectopic pregnancy Other (specify)		-11	23d. Date of Month		y Year
COLDS, T	equires that en signed b	by	Part II. Other significant conditions	contributing to death but in	not resulting in the un	nderlying cause giver	n in Part I.		pacco use contribu	ite to the ca	
ב	icien: The law r certilicate has be rector, page 2 sh	Completed						24a. Was au autops perform 1 Yes 2	prio dea	r to comple	findings available ation of cause of
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Physicien: r this certitics ral director, I	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatient	Othor		th <i>(Check only one</i> ome 5□ Reside		(Specify)	10 =0'. 1
	ng the line	Certification: 7	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati			28c. Injury a Work?	at	28d. Describe ho		<i>эрвыну)</i>	Viospics
Š	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Attercompletely filled in by the funer		3 Suicide 6 Could not determine	d 286. Place of Injury building, etc. (City or Town			
	ne Hosp 7 24 ho ne Fune detely fi	edical	29a. Certifier (Check only one) 1 Certifying F 2 Medical Ext	Physician: To the best of raminer: On the basis of examiner and manner stated	(amination and/or inv	occurred at the time estigation, in my opin	, date and place, nion, death occur	and due to the ca red at the time, da	use(s) and manne ite and place, and	or as stated due to the	cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	My -		29c. License	,	29	d. Date signed (N	Month, Day,	Year)
	7		30. Name and address of person who	o completed cause of deat	th (Item 23a) (Type, F	1010	8511		44,	7	2.0
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	Jaul P	1 Ba	14 more	md.	212	02
	Registr	_	APR 13	2005 Been	1 19						

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item/9, 12, 19a, perFH, 642, 4/20/05 Till State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 7 40 PM 50017-1 - IELDS 2003 7 ERTRUDE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HUSPITAL 13ALTIMORE 1 EDG CY NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number Min Hours Months Days 1 □ M 2 🛛 F MĎ Yrs. 3-28 217-24-3366 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Baltimore Md. NA 1 XYes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21218 1911 Boone Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes, Give 1 Never Married 2 Married 1 Yes 2 Nio Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Engineer **GBMC** 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robinson Jeanette Harrison Parish George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9721 Slalom Run Drive, Woodstock, Md. Gladys Gunn-Mose Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Garrison Forest Vet. 4-15-05 Md. Baltimore, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility 1101 E. North Ave. March F.H. East 23a. Part. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - 5 CHETIC 475 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or nijury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Whiknown DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 X Vo 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 2.7 is marked any injury or other 2. **Physician** /Medical Examiner Examiner

death certificate be executed

The law requires that the

Physician:

Hospital or Attanding

24 hours a Funeral C

within 24 hor To the Fune completely fi

P.O. Box 68760,

Division of Vital Records,

Physician

/Medical

Director

Completed by Funeral

Be

2

Examiner

Funeral

Director

Item 27 is marked other than "neturel", or Items 23e or 28a-1 show other traumatic evant. The Modical Expression interities inclified at

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

for use as the burial-transit detached pe director

Physician/Medical λq Be Completed

۵

Certification:

Medical

attending physician the þ signed page 2 should has certificate this After this funeral of after death. filled in by

IF FEMALE:	
23b. Was de	cedent pregnant
in the p	ast 12 months?
1 ☐ Ye	s 2 No

	as case aminer	referred	to	medical
1 [] Yes	2 N o		

Manner of Death 1 Natural

6 Could not be 3 ☐ Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier USTA.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

PLACE BALTAME, MA

29d. Date signed (Month, Day, Year)

2 1202

(0 JUS EPH 31. Date filed (Month, Day, Year)

32 Registrar's Signature

301 55

State Registrar

PAUL

			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment e rtificate			and M	ental Hy	giene Reg. No	005	12490
	Physici	an	1. Decedent's Name (First, Middle, Las	Mildred	Virginia	774		1_		2. Date of De Month	aath 10 ^{Day}	200 ^Y ear	3. Time of Death
	/Medic	al	40 English Nome (If not institution oil)		Virginia		nnic		(D 1)	<u>4</u>			19:30 M
1	Examin	er	4a. Facility Name (If not institution, give			4b. City, To		_ocation o	of Death		40. (County of Dea	ıth
	Funeral		Bon Secours Hosp 5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	Ba1	Year	If Under 2		8. Date of Bir	th	N/A 9. Bir	thplace (State or Foreign
	Director		214-22-1346	□ M 2(XF	82 Yrs.	Months [Days	Hours	Min.	Month, Pa	¹ 1922	C	Md Md
	pug *	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation							10d. Inside City Limits
	Marylan f show	ō	Md	N/A	Balto								1 Yes 2 □ No
	r 28a-f	rec	10e. Street and Number			10f. Zip Co	ode				10g. Citiz	en of What C	
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	1811 St Paul Str	eet Apt	1	21	1202				U	S A	
	after dea or items	Iner	11. Marital Status	12. Was Decedent E Armed Forces?				panic Orig	gin? (Spe	cify Yes or No Rican, etc.))- 1	4. Race - Ame Black, Whi	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give	0	1□Yes 2		Specify:	,	, , , , , , , , , , , , , , , , , , , ,		Specify: B1	
5-0036	72 hours after natural', or ite		15. Decedent's Ed	Year or Dates:	16a Deced	ient's Usual (Occupati	ion				d of Business	
215	within 72 ene. then "na	plet	(Specify only highest gra	de completed) College (1-4or 5-	(Give	kind of work of	done du retired)	iring most	of workir	ng			f
2121	ad with	Completed	8th grade	N/A	S	eamstr	cess				Na.	Manuf	Clothing
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				1	18. Mothe	r's Name	(First, Middle	, Maiden S	Sumame)	
ryla	2 should be illed within 72 hours and Mental Hygiene. Is marked other then "natural," aumatic event, I're Midical Exa	2	Frank E. William					Bern		Cager			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira Madical Examiner must be notified at 2008.		19a. Informant's Name/Relationship (1888) Brenda Hamlin —							≀Route Numb Ville,			Zip Code)
	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr ance.	1	20a. Method of Disposition		20b. Place of Dispo					ate		L / 04 ation - City or	Town, State
Baltimore,	Pages ent of nt: if i		1 Burial 2 □ Cremation 3 □ 3 4 □ Donation 5 □ Other (Specify		Garrison			į.	/ ₋₁₅ .	2005	Orada	. Md 1	11 - M4
alti	permit. Departminental Importal any inju	1	21. Signature of Funeral Service Licen		The state of the s	. Name and A				March F			lls, Md
ω_	88.58		Synette	K. Ju	nes)		430	00 Wa					1 21215
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	plications that aused in each line	9.	er the mode o		0					Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):			u	NA	aref	<u> </u>		
	Examiner		Sequentially list conditions	b									
	sit ad	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of								
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a	consequence of):								
8760,	sician buriá	alE		d									
89	ifficate g phy as the	edic		u									
Вох	leath certifica attending pt I for use as t	Physician/Medical	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome o		Ectopic pregr	nancy				23	d. Date of de	,
Э. Е	e dea the at ned fo	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t 9☐ Unknown		Other (special			-			Month	Day Year
P.0.	that the de led by the a detached t		Part II. Other significant conditions of	entributing to death but	t not resulting in the un	dorhing caus	so given	in Part I		23e Did t	obacco us	a contribute to	the cause of death?
Records,	90	Completed by	Dement	ف	thot tobuiling in the u	raerrying caus	ae giveii	in Fait i.			Yes 2		
CO	w requires been si should I	lete	Congre	ive H.	east	Eas	0.0	20		24a. Was	an	24b. Were au	utopsy findings available
Re	sician: The law certificate has b lirector, page 2 s	mo l								autor perfo	osy rmed2 2 No	prior to death? 1 \(\sum \text{Yes}\)	completion of cause of
		BeC	25. Was case referred to medical examiner?				2	26. Place	of Death	Check onl		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2L NO
of Vital	Physic this ce al dire	၉	1 Yes 2 No	Hospital: 1 Napatien			Other:	4 🔲 Nul	sing Hom	ne 5 ☐ Resid	dence 6	Other (Spe	cify)
o u	ding P. h. After t funera	Ü	27. Manner Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury		Injury a Work?			8d. Describe I	now injury	occurred	
Division	Attendideath. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be		ry - At home, farm, stre	M ot factors of		s 2 N		Rf Location /	Straat and	Number or B	ural Route Number,
Σİ	after after Direction	Certification;	4 ☐ Homicide determined	building, etc.	(Specify)	et, lactory, or	itice		-	City or Tox		INGINDER OF AL	irai nobie ivariber,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Ph. 2 Medical Exam	ysician: To the best of iner: On the basis of and manner state	examination and/or inv	occurred at t	the time, my opin	, date and nion, death	i place, a h occurre	nd due to the	cause(s) a date and p	nd manner as	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier	and manner state		29c. Li	icense r	number			29d. Date	signed (Mont	h, Day, Year)
		/	I strul Uba	year mi)	D	26	574	78		41	121	2005
1	11		30. Name and address of person who	completed cause of de			0		0				
			ANIL UBER	OL 4-	Slave B		K	D	136	7170	IN.	1) 01 3	又 [[

			1 - For State Registrar	State o	f Marylan		artment rtificate			and M	lental H	ygier Reg. 1	, m		1010
	Physici	an.	Decedent's Name (First, Midd		_						2. Date of I		Day_	Year	3. Time of Death
,	/Media	cal.	SYLVIA		F.			0 X	1	4 Do oth	APRIL		2005	f Da ath	3:00 A M
	Examir	ner	4a. Facility Name (If not institution HOSPICE OF BAL			CTR.	4b. City, I	own, or	Location o	VSON		1	4c. County o	ALTI	MORF
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under	1 Year Days	If Under		8. Date of 8	Birth			lace (State or Foreign
	Director		260-24-0988	1□M 2MF	78	Yrs.	MOTHERS	Days	Hours	IVIII I.	FEB.1	4,19	127		OH
	rland ow		Usual Residence of Decedent 10a. State 10b. County	1	10c. Cit	y, Town or Lo	cation							1	Od. Inside City Limits
	Many B-f sh	tor	MD	N/A		BALT	IMORE								1 X Yes 2 □ No
	72 hours after death with the Maryland hatural', or Itams 23a or 28a-f show dical Examinat roust be notified at	by Funeral Director	10e. Street and Number				10f. Zip	Code				10g.	Citizen of W	hat Cour	
	s 23a	erail	6350 RED CEDA			6 12	No a December	and of tile	2120		#V		14 Page	Amoria	USA ean Indian,
"	fter de r Itam liner	Fun	11. Marital Status 1 □ Never Married 2 💢 Mar	Armed Fo					n, Mexican	, Puerto	ecify Yes or P Rican, etc.)	¥O-		, White,	
5-0036	ral, o	by	3 Widowed 4 Divorced	If Yes, Gi Year or D	ve Avates:		1 □ Yes 2	No.	Specify:				Specify:		WHITE
5-0	2 should be filed within 72 hours after dea and Mental Hygiene. Is markad other than "natural; or Itams raumatic event. It a Medical Examination	Completed		nt's Education est grade completed)		(Give	dent's Usual kind of work	k done di	uring most	of work	ing	16b.	Kind of Bus	iness/Inc	dustry
2121	within ene. than "	фшс	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DO NOT us</i> e RVISOI					CI	TY OF	BAL	TIMORE
	il Hygi othar /ant. I	e C	17. Father's Name (First, Middle,	Last)		00. 2			18. Mothe	r's Name	e (First, Midd				TITIONE
/lar	wid be Menta arkad atic av	To Be	(UNKNOWN)			WOLF			(۱	INKNO	OWN)			.,	FELDMAN
Maryland	s 1 and 2 should be filed within 72 hc if Health and Mental Hygiene. item 27 is marked other then "natur other traumatic event. The Medical		19a. Informant's Name/Relation:				-				al Route Num				
_	1 and Health am 27 thar tr		SAM FOX / HUS	DONNU	20b. P	lace of Dispo	sition (Nam	e of	1		74UZ -	_	Location - 0		D 21209
nor	ages ent of nt: if it y or o		1 🛱 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State	emetery, crer SINAI	natory or oti	her place		14/11	1/2005				LLS, MD
Baltimore	permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr once.		21. Signature of Funeral Service		μintix	22	. Name and	Address	s of Facilit	SOL	LEVII	NOSV	& BR	os.,	
			23a. Parh. Enter the disease of shock, of heart failure. Lis	r complications that of	caused the death									,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	A	myo.	trop	ic L	-at	EVA	(5	scler	o Si	5		Onset and Death
	/Medical- Examiner		resulting in death)	Due to	(or as a consequ	uence of):									J
		P.	Sequentially list conditions,	b. Due to	or as a consequ	uence of									
V	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	5											
0,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to	(or as a consequ	uence of);									
8760,	cate be ohysici the bu	dicai		d	-										
9	ding p	/Mec	IF FEMALE:	23c If yes ou	tcome of pregna	ency/	-		-					1	
Вох	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	oirth 2 Fetal	I death 3	Ectopic pre						23d. Date Mont		Day Year
0	t the d by the ached	hysi	1 □ Yes 2 2 No 9 □ Unknown	9□ Unkn	own										
s, P	w requires that s been signed E s should be dek	by P	Part II. Other significant condition	ions contributing to d	eath but not resi	ulting in the u	nderlying ca	iuse givei	n in Part I.		23e. Dio	l tobacc			e cause of death?
ord	requir sen si	ted									1] Yes	2 KNO :	Prob	ably 4 Unknown
Records,	e law has b je 2 st	nple										s an opsy formed:	pr	ere auto ior to cor ath?	psy findings available apletion of cause of
alF			05.14								1 ☐ Yes	2/21			2 No
Vital	Physician: this certific ral dire tor,	ToBe	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Dutpatien	t 3 DO	Other	-		n <i>(Check only</i> me 5 ☐ Re		6 AOther	(Specifi	Harriso
o r	무무	n: T	27. Manner of Death	28a. Date		28b. Time of Injury		Bc. Injury Work			28d. Describe		1 ~		10 pt
Sior	Attanding ir death. actor; After by the fune	catic	Z L Accident	igation			М	1 🗆 Y	es 2 🗆 l	No					
Division	or Att	Certification:	3 Suicide 6 Could 4 Homicide deterr	nined 286. Place	of Injury - At ho ing, etc. <i>(Specif</i>)	ome, farm, str y)	eet, factory,	office			28f. Location City or T			or Rura	l Route Number,
J	spital ours a naral [29a. Certifier 1 Certifyi	ng Physician: To the	best of my kno	wledge, death	occurred a	it the time	e. date and	d place.	and due to th	e cause	(s) and man	ner as st	ated
	To the Hospital or Attanding is within 24 hours after death. To the Funaral Diractor; After completely filled in by the funer	edicai	(Check only 2 Medical one)	Examiner: On the band man	asis of examina ner stated.	tion and/or in	estigation,	in my opi	inion, deat	h occurr	ed at the time	a, date a	ind place, ar	nd due to	the cause(s)
	To the To the composition	Σ	29b. Signature and title of certific	er 11	10		29c.	License	number			29d. [Date signed	(Month, I	Day, Year)
	1		Il the	thong !	rles	m	1)	25	300			/t x	01:1	7,2	005
	5			who completed cause	se of death Illian	23a) (Type,	Print)	mmo	E 07	7011	7007	(1-)	_	0-	MC . \
	Sta	ate	31. Date filed (Month, Day, Year) 32. F	Y #650 Registrar's Signa	ture	ure (1	THUK	0	LCH	الملك ا		. (0	رب	ra mp
	Registi		Ų.	PR 1 3 2d	05 Blen	1 23a) (Type, TCE OF Iture	5. A	OB 484							

			1 - For Stata Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H		, ,	ene . No.2 0 0 5	12492
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year	3. Time of Death
5	/Medic Examin		Wanda T. Fleisch 4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	April 9,	2005 4c. County of Death	6:30P M
			Genesis Eldercar	e Hamilton		Baltimo	ore		N/A	
	Funeral Director		213-10-98/8	COURS AND ADDRESS OF THE PARTY	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthp Cour 3 Mar	elace (State or Foreign etry) yland
	land m m		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	Mary a-f sh	tor	MD N/A		Baltin	nore				h∰Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cour	ntry?
	ath w	rai	4626 Kavon Avenu			21206			U.S.A.	
	Itam Itam	nn	11. Marital Status 1 Never Married	12. Was Decedent En Armed Forces? 1 ☐ Yes 2 ☑ No	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	14. Race - Americ Black, White,	
98	al', or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1☐ Yes 2√√ No	Specify:		Specify: Wh	ite
20	within 72 hours atter death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Madical Excipirat must be mullified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing 16	b. Kind of Business/In	dustry
121	within ane. than '	jdmo	Elementary/Secondary (0-12)	College (1-4or 5+	1	<i>DO NOT u</i> se retired 1emaker)		Own Home	
2 2	filed Hygi othar ant.	Be Co	12 17. Father's Name (First, Middle, Last)		1		18. Mother's Nam	e (First, Middle, Mai		
<u>la</u> n	uld be Mental irkad o	To B	Alexander Paris				Katarzy	na Kwasni	ewska	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It a Madical Examination at a published at Once.		19a. Informant's Name/Relationship (ity or Town, State, Zip	
	1 and Health Bm 27 thar tr		20a. Method of Disposition	/ nusbanu	20b. Place of Dispo				aryland 21 c. Location - City or To	
altimore,	Pages nent of h int: If its iry or of		1 □ Burial 22 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		cemetery, crei	matory or other place	e)			
<u></u>	permit. P Departme Importan any injur.		21. Signatura Tunera Service Licer	- 7		ke Cremat			eltsville, el Funeral	
Ö	Per Per Suny Suny Suny Suny Suny Suny Suny Suny		Vistas /		6	415 Belai	r Road B	altimore,	Maryland	21206
>	Fnysician /Medical Examiner		23a. Part 1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Ahr	ne death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	nsequence of):	40				
	be executed sician and burial-transit	Examiner	that initiated events	c. De	mente	2				
8760,	ate be exe hysician a the burial-	EX	resulting in death) Last	Due to (or as a	consequence of):					
687	physi s the	edicai		. d	Vn. Carrey					
О. Вох	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached tor use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
rds, P.	quires that the de n signed by the a uld be detached t	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to the	
Vital Records,	sician: The law requir s certiticate has been si irector, page 2 should I	Completed						24a. Was an autopsy performed	prior to cor death?	osy findings available npletion of cause of
/ita	cian: ertitica ector,	Bec	25. Was case referred to medical examiner?	Handad.				h (Check only one)		
ot	Attanding Physician: r death. actor: After this certitics by the funeral director.	To.	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatier		4 LTNursing Ho	me 5 Residence	e 6 Other (Specify)
O	ding th. After funer	tion	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Work	ration (?) Yes 2 □ No	20d. Describe now	injuly occurred	AAAA-en serve
Division of	al or Attandi after death Diractor: A d in by the f	Certification:	3 Suicide 6 Could not by determined		y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier Certifying Ph (Check only one) Certifying Ph	ysician: To the best of tinar: On the basis of e and manner state	xamination and/or in	h occurred at the tim vestigation, in my op	e, date and place, pinion, death occur	and due to the caus red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2-	Ň	29b. Signature and title of certifier	2	MI	29c. License			Date signed (Month,	Day, Year)
,	~		1	200	_		31461		4/11/07	
10			30. Name and address of person who	781 ton 18	th (Item 23a) (Type,	Print) Entire	87 An	te 308	Balt-r	ng 2/20)
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3	2005 32. R	s signature s					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician **JAMES** OTIS APRIL 5:25A GRANT 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY Mariner Health at Circle Manor Kensington If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Months Days 1**2** M 2 □ F Director Aug. 24,1930 Virginia 227-40-3898 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State iral', or Itams 23a or 28a-f shov Examinar must be notified at 1X Yes 2 No Director D.C. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6144 First Place, N.E. 20011 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours atter onent of Health and Mental Hygiene. ant: If item 27 is marked othar than "natural", or Ital XYes 2 No 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2€ No Specify: Yes. Give Specify: Black 3 Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Entrepreneur Fish Market itam 27 is marked oths other traumatic avant, 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Thomas Grant 2 <u>Juanita Sherman</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elmer Grant / Brother 6134 First Place, N.E. Wash., DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 10 H 10 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Quantico Nat'l Cem. Triangle, VA 4-16-05 22. Name and Address of Facility Capitol Mortuary, Inc. of uneral Service Lines see 21. Signatur 1425 Maryland Ave., NE Wash., DC 23a. Part1. Enter the disease, or c shock, or heart failure. List or mplications that caused the death. Do po enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASPIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner and I-transit The law requires that the death certificate be executed KIDNEY DISEASE that initiated events resulting in death) Last Due to (or as a consequence of): physician a 68760 Box (IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year ö 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 2 No 1 ☐ Yes 27 No of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: W Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 🗶 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide vithin 24 hour. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4-12-2005 H0051280 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a D. C. 9715 Madical Center Ste #201 DADGAR. Rockville, Md. 32. Registrar's S ature

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

Carren

			For State	Sta	te of Ma	•		artment of H rtificate of I		Mental Hy	•	0000	
			1. Decedent's Name (First, Mid	Idle. Last)			001	tineate of t	Jean	2. Date of De	Reg. N	10.2 1115	3. Time of Death
	Physici		Sidney Grotsk							April		2005 Year	2005 M
	/Medio Examin		4a. Facility Name (If not institut		nd number)			4b. City, Town, or	Location of Deat			c. County of Deat	
1	Examili	٠.	Gilchrist Cen	ter for	Hospi	ce Care		Towson				Balti	
	Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last birtl	hday)	If Under 1 Year	If Under 24 Hrs Hours Min.	8. Date of Bi	rth	9. Birt	hplace (State or Foreign
	Director		112-09-4987	1□M 2[X	^{□ F} 93	Υ	rs.	Months Days	Hours Mill.	8. Date of Bi (Month, D May 10	, 1	911 Ne	w York
	pur A		Usual Residence of Decedent 10a, State 10b, Cour	ity		10c. City, Town	orto	cation					10d. Inside City Limits
	faryla sho	ក											1 ☐ Yes 2 ☐ No
	the A	ect	Md. Balt 10e. Street and Number	imore		Pike	esv	10f. Zip Code			10a C	Citizen of What Co	
	eath with the Maryland is 23a or 28e-f show	흐	8521 Snowreat	h Road				2120	8		-	.S.A.	unity:
	death with the Maryland ms 23a or 28e-f show Frast be rediffed at	Funeral Director	11. Marital Status	12. Wa	s Decedent E	Ever in U.S.	13.	Was Decedent of Hi f Yes, specify Cuba		Specify Yes or N		14. Race - Ame	rican Indian,
215-0036	or ite	by Fur	1 ☐ Never Married 2 ☐ M	arried 1 [ned Forces?]Yes 2 ∰\ es, Give ar or Dates:	10		fYes, specify Cuba 1□Yes 2⊡KNo	n, Mexican, Puer Specify:	to Rican, etc.)		Black, White	e, etc. hite
0	72 hours netural,	Completed		ent's Education	In to all	16a.	Dece	ient's Usual Occup	ation		16b.	Kind of Business/	Industry
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21	se filed within all Hygiene. I other than vent, the Me	Con	9 years			ma	ach	inist				aviatio	n
pu	be fill d off	Be	17. Father's Name (First, Middle							me (First, Middle		en Sumame)	
<u>Y</u>	2 should be f and Mental h is marked of raumatic eve	^C	Abraham Grots	_	- 5					Kassell			
Maryland	d 2 st th and th sr 27 is r traur		19a. Informant's Name/Relation Jeffrey N. Gr		•			ng Address (Street a					
ē,	t Health Hem 27 i	- 8	20a. Method of Disposition					sition (Name of natory or other plac		Date		Location - City or	
9 2	Pages entor nt: If i		1 ☐ Burial 2 ☐ Crematio 1 ☐ Donation 5 ☐ Other		I from State			elawn Cen		2/2005	C1	ifton, N	.J.
Baltimore,	permit. Pages 1 an Depertment of Heal Important: if Item 2 eny injury or other once.		21. Signature of Puneral Servi		01		22	Name and Address Schimunek	s of Facility Funera	l Home o	f B	el Air,	Inc.
			23a. Part1. Enter the disease,	or complications	that caused	the death. Do no		610 W. Ma				ir, Md.	21014 Approximate
	D		shock, or heart failure. L. Immediate Cause (Final	ist only one caus	e on each lin	10.		blasti			,		Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a	Oue to (or as	a consequence o		OCAZI	C Ar	CWITZ	+		years
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	ding p		IF FEMALE:	23c If ve	as outcome	of pregnancy					1		
D. Box	The law requires that the death certific te has been signed by the attending f tage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 <u></u>	Live birth	2 Fetal death time of death		Ectopic pregnancy Other (specify)				23d. Date of deli Month	very Day Year
P.0	that the de ned by the a detached f	Ph)	Part II. Other significant cond	itions contributin	o to death b	ut not resulting in	the u	nderlying cause give	an in Part I	23e Did	tobacco	use contribute to	the cause of death?
Division of Vital Records,	quires that n signed I	ed by										1	obably 4 □Unknown
000	aw requir s been si 2 should	Completed								24a. Was		24b. Were au	topsy findings available
R	The law cate has page 2:	mo				-				auto perf	ipsy ormed? 2 √ 2 N	death?	completion of cause of
ital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medi examiner?	cal					26. Place of De	ath (Check only		.0 ,2.00	20110
>	d S	Tol	1 ☐ Yes 2 No	Hospital	1 ☐ Inpatie	nt 2□ER/Out	patier	t 3 DOA Othe	er: 4 ☐ Nursing H	dome 5□Res	idence	6 Other (Spec	in Hospice
n o	gran erri	on:	27. Manner of Death 1 Natural 5 □ Pen		Date of Injur (Month, Day	y 28b. Ti	ime o ijury	Work		28d. Describe	how inj	ury occurred	
Sio	Attending or death. ector: After by the fune	cati	2 Accident inve	stigation					Yes 2□No	201	10.		
Div	at or A s after it Direct	Certification;	4 ☐ Homicide dete	rmined 289.	building, etc	c. (Specify)	m, str	eet, factory, office		City or To			ıral Route Number,
	Hospita 24 hours Funera stely fille	edical (Zea. Centilier 1 Centilier (Check only 2 Medicone)	al Examiner: On	To the best on the basis of dimanner sta	examination and	, dead	occurred at the time vestigation, in my of	ie, date and place pinion, death occu	e, and due to the urred at the time	cause(s) and manner as nd place, and due	stated. to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Med	29b. Signature and title of cert		//	1.0	,	29c. License	number		29d. D	Pate signed (Month	n, Day, Year)
1	1	/	30. Name an address of pers	on who complete	d Juse of de	eath (Nem 23a) (Type,	Print)	3203	0. 2	MA	OVIL	1,2005
1	/(I'')		31. Date filed (Month, Day, Ye.	(ey (32. Registra	1 C G >	70	1 11-C	harle	St. Bo	elt.	D. CAN	21204
	Sta Registr		A P	R 1 3 2	205	Delene.	K	Soule					
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			State of Maryla 23a&27 per me				10.000 (5		· CUU5	
Physici	ian	1. Decedent's Name (First, Middle, La George E. Grimm	,				2. Date of D		005 Year	3. Time of Death
/Medi		4a. Facility Name (If not institution, gi			Ah Cihi Tours	or Location of Deat	April			8:23 A
Examir	ner		ve sireer and number)				.n	40.	. County of Death	
unaval		Glen 3 Lot 325 5. Social Security Number 6.	Sex 7. Age (In y	rs. last birthday	Farlevi	Ti Under 24 Hrs	8. Date of 8	irth	Cecil 9 Bidbe	place (State or Fore
uneral irector			1₽M 2□F 66	Yrs.	Months Days		. (Month, L	ay, Year)	938 Penns	ntry)
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how		10a. State 10b. County		City, Town or L					1	IOd. Inside City Lin
a-fa	cto	PA Delawa	re	C	hester Tw	p.				1 ☐ Yes 2 2 ☐
d other than "naturel", or liems 23a or 28a-4 show event, the Madical Examiner must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Cour	ntry?
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tems	nne	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S ean, Mexican, Puer	Specify Yes or Note to Rican, etc.)	10-	14. Race - Americ Black, White,	
o i	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No 10		1 ☐ Yes 2 ☑ No	Specify:				nite
turel	be be	15. Decedent's E		957	edent's Usual Occup			105 (4)		
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other ent,		12 years 17. Father's Name (First, Middle, Las	it)	mecn	anic	18. Mother's Nar	me (First, Middl			18
marked other than "naturet; or liems 23a or 28a-f show imatic event, the Madical Examiner must be notified at	To Be	George E. Grim	m, Sr.			Grace	Zurman			
item 27 is marked r other treumatic e	-	19a. Informant's Name/Relationship		19b. Mail	ing Address (Street	and Number or Ru	ura / Route Num	ber, City o	r Town, State, Zip	Code)
27 ls		Dorothy Grimm/	wife		3 Carter					
item 27 other tr		20a. Method of Disposition	1	. Place of Disp	osition (Name of ematory or other pla	(00)	Date	20c. Lo	ocation - City or To	own, State
nt: If it ry or o		1 ☐ Burial 2 ☐ Cremation 3 § 1 ☐ Donation 5 ☐ Other (Special Control of Cont		-	s & Co.		/2005	West	Chester,	, PA
Importent: If any injury or once.		21. Signature of Funeral Service Lice	•	2	2. Name and Addre	ess of Facility				
any Sug			to (Schimunek	Funeral	Home o	f Bel	L Air, Ir	ic.
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	Physici	an	Decedent's Name (First, Midd	le, Last)				2. Date of D Month	eath Day	Year	3. Time of Death
	/Medic		THOMAS	EDWARD	HIRSCH,	JR.		April	05 0	2005	02:54 M
F	Examir	er	4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, o	or Location of De	eath		y of Death	
				coral Medien		Sal	isbury	-		hiconic	
	Funeral Director		5. Social Security Number 215-30-8844	6. Sex 7. Age 7. Age 70	e (In yrs. last birthday Yrs.	Months Days	Hours M	in. (Month, E	irth 2ay, Year) 1, 1934	9. Birthpla Country MARYI	ce (State or Foreign y) AND
	and		Usual Residence of Decedent 10a. State 10b. County	/	10c. City, Town or L	ocation		·		100	d. Inside City Limits
	Manyl f sho	ō	VA ACCOMA	CK	ONANCOC	K					1 ☐ Yes 2 ☑ No
	fhe 28a	rec	10e. Street and Number		02/22/1000	10f. Zip Code			10g. Citizen of	What Countr	v?
	3a or	Funeral Director	15206 RUSSELL	DRIVE		23417			τ	JSA	
	ms 2	era	11. Marital Status	12. Was Decedent E	Ever in U.S. 13.	. Was Decedent of I If Yes, specify Cub	tispanic Origin?	(Specify Yes or N		ce - Americar	
21215-0036	s 1 and 2 should be filed within 72 hours after death with fhe Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Madical Exaris at must be notified at	by Fur	1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give 21	lo	1 ☐ Yes 2 🛣 No		erto Hican, etc.)		ick, White, et ^{fy:} WHIT	
ŏ	2 hou	Completed	15. Deceder	nt's Education	16a. Dec	edent's Usual Occup	pation		16b. Kind of E	Business/Indu	stry
215	hin 7.	pie	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4or 5-	+) (Giv.	e kind of work done DO NOT use retire	during most of w d)	vorking			
7	d wifi giene er the	E O	12	1		RINTER			PRIN	ITING	
g	be filed ttal Hygid od other event.	Be (17. Father's Name (First, Middle,					lame (First, Middl			
Maryland	2 should be filled within and Mental Hygiene. is marked other than aumatic event, the Me	2	THOMAS EDWAR. 19a. Informant's Name/Relations	D HIRSCH, SR. ship (Type, Print)		ling Address (Street		CATHERI:			ode)
	and 2:		CATHERINE SHIR	LEY HIRSCH (W		206 RUSSE					
altimore,	permit. Pages 1 and 3 Department of Health Important: if item 27 any injury or other tr once.		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other pla	ce)	Date	20c. Location	- City or Tow	n, State
Ë	Pages nent of l int: if its iry or o		1 ☐ Burial 2 X Cremation 1 ☐ Donation 5 ☐ Other (5		1	OCK CREMA	· 1	7/05	EXMORE,	VA	
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m	Per in Per	. 10	Carl 4	Thosal		24183 CH	ADBOURN	E ST 1	PARKSLEY	, VA 2	3421
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that caused t only one cause on each line	the death. Do not er	nter the mode of dyir	ng, such as card	iac or respiratory	arrest,	- Ir	Approximate nterval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Metasi	tapic Eso	phageal	concur		4	money
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):	,					
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Вох	death certifica attending plands as to	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Te			23d. Da	ate of delivery	
m.	death e atte	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t		□Ectopic pregnancy □ Other (specify) _	/		Me	onth Da	ay Year
P. 0.	that the de ed by fhe a detached t	hys	9 🗌 Unknown	9□ Unknown							
	se do	by F	Part II. Other significant conditi	ons contributing to death bu	it not resulting in the i	underlying cause giv	en in Part I.		tobacco use con		
ord	w require been si should l	ted						1 🗆	Yes 22No	3 Probab	ily 4 ∐Unknown
Vital Records,	e law r has be ge 2 sh	Completed						24a. Waa	psy	Were autops	y findings available lietion of cause of
Ξ.		Con							ormed? 2 No	death? 1 ☐ Yes 2	□ No
ita	ician: Th certificate rector, pag	Be (25. Was case referred to medica examiner?					eath (Check only			
<u> </u>	Physia this c	은	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatier				Home 5□Res			
Ē	ding P h. After t funera	iuo!	27. Manner of Death 1 Natural 5 □ Pendir		Year) 28b. Time of Injury	Wor	k?	28d. Describe	how injury occur	red	
Sio	flend leath tor: / the f	cat	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be	***		Yes 2 □ No	204 Leasting	/C4		2
Division of	I or Attendater deatl	Certification;	4 Homicide determ		ry - At home, farm, st . (Specify)	reet, factory, office			(Street and Numl wn, State)	per or Hurai H	route Number,
	Hospital 24 hours a Funeral I stely filled		29a, Certifier 1 Certifyin	ng Physicien: To the best o	f my knowledge, dea	th occurred at the tir	no data and nia	and due to the	cauca(c) and m	agar ag state	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	egical	(Check only 2 Medical one)	Exeminer: On the basis of and manner stat	examination and/or in	nvestigation, in my o	pinion, death oc	curred at the time	, date and place,	and due to th	e cause(s)
	To the within 2 To the complet	E	29b. Signature and title of certifie	ir		29c. Licens	e number		29d. Date signe	d (Month, Da	y, Year)
•	A	'	> 2 to Note			D051	354		Apri	15/52	005
İ	01		30. Name and address of person	·	1.1	-					
_	v		Dr. USITA NAT		1415.5.0	1V1512N 5	7, 3AL	15BURY	40 2180	4	····
	Sta Registr		APR 1 3 20	32. Registra	r's Signature	6.0					1
	. ricgisti	ear	, 0 0	- MANAGENES !	W. William						

		,	1 _ State	Department of Health and M Certificate of Death	-	ne nns	12498
			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	140.	3. Time of Death
	Physicia	an	Rose P. Hayward		April 7.	Day 2005	6:36 P M
111	/Medic		4a. Fecility Name (If not institution, give street and number)	4b. City. Town, or Location of Death	April 1	4c. County of Death	0.30 F
	Examin	er	908 Monica Circle	Kingsville		Harford	-1
			5. Social Security Number 6. Sex 7. Age (In yrs. last bit		8. Date of Birth		
	Funeral Director		216-78-4573 1□ M 2♥ F 89	Yrs. Months Days Hours Min.	(Month, Day, Ye	1916 Mary	lece (State or Foreign try) Land
	and w.		10a. State 10b. County 10c. City, Tow	n or Location		1	0d. Inside City Limits
	Aary f sho	0	Maryland Harford	Kingsville			1 Yes 2 No
	the 1	Director	10e, Street and Number	10f. Zip Code	10a	Citizen of What Coun	
	with B or		908 Monica Circle	21087		U.S.A.	•
	eath	Funeral			acify Yas or No-	14. Race - Americ	
	er de Item	Š	Armed Forces?	13. Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
36	rs aff	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 2 1 No If Yes, Give 3 2 Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🕱 No Specify:		Specify: (Ihite
8	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Gral Examinet must be notified at	pa		. Decedent's Usual Occupation	16	o. Kind of Business/Inc	fustry
<u>1</u>	in 72	olet	(Specify only highest grade completed)	(Give kind of work done during most of work life. DO NOT use retired)	ing		,
12	filed within Hygiene. ther than "ther than"	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Own Home	2
D			17. Father's Name (First, Middle, Last)	18. Mother's Name	First, Middle, Mai	den Sumame)	
a	Mental Mental arked c	To Be	Grover C. Hinkle	Ruth	C. Lwrz		
Maryland 21215-0036	s 1 and 2 should by f Health and Menta Item 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship (Type, Print) 19t	b. Mailing Address (Street and Number or Rura	al Route Number, C	ity or Town, State, Zip	Code)
	and 2 ealth a n 27 is		Mr. Kenneth Hayward (son) 9	08 Monica Circle, Kir	igsville,	MD 21087	
Baltimore,	s 1 and f Health Item 27 other tr			of Disposition (Name of Inry, crematory or other place)	Date 200	c. Location - City or To	wn, Stete
5	m 0		1 XI Burial 2 Cremation 3 Hemoval from State		2005 B	ultimore, N	Nanul and
Ξ	그는 원급 .		21. Signature of Europal Pervice Consee			Funeral Hon	
B	Depa Impo any i		A CONTRACTOR	9705 Belair Rd., Bo			1100
	D co		23a. Part. Enter the disease, or complications that caused the death. Do				Approximate Interval Between
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	eumonia.			Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Due to (or as a construence				
450	Examiner		Due to (di as a cons a dence	orj.			
		- G	Sequentially list conditions, if any, leading to immediate cause. Entire Lindertying.	of):			
	nsit	e le	Cause (Disease or injury				
•	axecu al-tra	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence	of):			
760,	te be executed ysician and ie burial-transit	calE					
687	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		0.				-
×	certii nding Ise a	Š	1F FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	_		23d. Date of delive	ıry
Вох	atter atter	clar	in the past 12 menths?	1 3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
o.	at the de by the a tached	Physician/Medi	1 Yes 2 No 9 Unknown 9 Unknown				
Ω.	res that igned b be deta		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
of Vital Records,	uires sign	d by	unosersis		1 ☐ Yes	2 ☐ No 3 ☐ Prob	abiy 4 🗆 Unknown
00	w requir been si should	Completed	aOzhernen Demoita		24a. Was an	24b. Were auto	psy findings available
Re	The tav	ᇤ	Carlottic Pacat fer	04.00	autopsy	prior to cor death?	npletion of cause of
a		ပိ	Constitute Than Jan	00 Bloom of Board	1 Yes 2	No 1 Yes	2 No
₹		o Be	25. Was case religited to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/O	Othors	(Check only one)	- 6 MOther (Co)	1
of	Phys rthis raidi	H 1	27. Manper of Death 28a. Date of Injury 28b.	utpatient 30 box 40 Hursing No	28d. Describe how	e 6 Other (Specify injury occurred	//
Du	ding F h. After funer	tlon	Natural 5 Pending (Month, Day Year)	Time of 28c, Injury at 1 Work? M 1 ☐ Yes 2 ☐ No			
S	or Attendiater death. Director: A in by the fo	lica	3 Suicide 6 Could not be 28e. Place of Injury - At home, for		28f. Location (Stree	t and Number or Rura	I Route Number,
Division	for A after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, S	State)	
	spite ours nerel filled		29a. Certifier Certifying Physician: To the best of my knowledg	e, death occurred at the time, date and place,	and due to the caus	e(s) and manner as st	ated.
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Medical	(Check only one) Medical Examiner: On the basis of examination at and manner stated.				
	Vithin o the ompl	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
	- > - 0	2/	Musa Sullan	D37364	At	XIL 8, 21	005
./	118		30. Name and address of the 2 n who completed cause of death (Item 23a)	(Type, Print)	7-13		
1			18 Worth Lane. Als	erdeen, Mary	Land		
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registi		ADD 13 2005 Marches	S. South			

DHMH 17 Rev 1/2001

ORIGINAL

	State of Maryland Departs Amend Item 9&10g per fh G 42 42 10 1	artment of Health and Mer 3-05 tas tificate of Death	ntal Hygiene	12490
Physician	1. Decedent's Name (First, Middle, Last) George John Hehring	2.	Date of Death Month Day Year Pril 10, 2005	3. Time of Death 9:00 P
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 2708 Page Drive	4b. City, Town, or Location of Death Baltimore	4c. County of Dea	ath
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 215-40-9591	If Under 1 Year If Under 24 Hrs. 8.		rthplace (State or Foreign
Maryland -f show lied at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo MD Baltimore Balti			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
with the 3a or 28a 1 be notified	10e. Street and Number 2708 Page Drive	10f. Zip Code 21222	10g. Citizen of What C	ountry?
be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or Items 23a or 28a-f show event, Ite Madical Examiner must be notified at Be Completed by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rici 1 ☐ Yes 2 ☐ No Specify:	Yes or No- an, etc.) 14. Race - Am Black, Whi Specify: Wh	ite, etc.
ed within 72 hou ygiene. aar then "nature t, tre Midlest Completed	(Specify only highest grade completed) (Give life. I	dent's Usual Occupation kind of work done during most of working DO NOT use retired) pping Clerk	16b. Kind of Business	s/Industry al Manufa
id be filed vental Hygie ked othar ic event, to Be Co	17. Father's Name (First, Middle, Last) Louis John Hehring		irst, Middle, Maiden Sumame)	ar nanara
d 2 shoulth and M 7 is mark	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	ng Address (Street and Number or Rural Re Page Drive, Bal		
Pages 1 an lent of Heal nt: If item 2 ry or other	20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State	osition (Name of natory or other place) Crematory 4/12/	20c. Location - City o	r Town, State
permit. Pages : Department of H Important: If ite eny injury or of once.	21. Signature of Funeral Service Licensee 22	2. Name and Address of Facility Bradley-Ashton F	uneral HOme,P	
death certificate be executed e attending physician and ad for use as the burial-transit sician/Medical Examiner	shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			Approximate Interval Between Onset and Death Minu Fes Unikawan
nat the death certifica d by the attending phetached for use as the		□Ectopic pregnancy □ Other (specify)	23d. Date of de Month	elive r y Day Year
igner igner igner be d	Part II. Other significant conditions contributing to death but not resulting in the u Agnon Four taresay Canebra ascular Azardan		23e. Did tobacco use contribute	to the cause of death? Probably 4 □Unknow
The law requires that the cate has been signed by the page 2 should be detached.	Carebravasenla Azadan	7	autopsy prior to performed? death?	autopsy findings available completion of cause of
cien sertific ector	25. Was case referred to medical examiner?	26. Place of Death (C	heck only one)	
fte ng	1 Yes 2 No Pospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined determined	of 28c. Injury at 28c Work? M 1 ☐ Yes 2 ☐ No	. Describe how injury occurred Location (Street and Number or F	
spi non ner ner ai	29a. Certifier Certifying Physician: To the best of my knowledge, deat			
To the Hosp within 24 hou To the Funel completely fill Medical	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Farman DC) 31. Date filed (Month, Day, Year) APR 1 3 2005	29c. License number \$\hat{\mathcal{D}} \psi \O	29d. Date signed (Mor	nth, Day, Year)
10-9	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 7602 326	111 D 21236	
State Registrar	31. Date filed (Month, Day, Year) APR 1 3 2005 Registar's Signature	Spare		

certificate be executed Box 68760, o σ. of Vital Records, or Attending

burial-transit attending physician the as use ŏ signed by the a d be detached to neec has page 2 certificate After thi funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

2

Examiner

by Physician/Medical

Completed

Be

2

Certification:

Medical

29a. Certifier

Funeral

Director

ir than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

within 72 hours after

al Hygiene.

2 should be finand Mental Finand Mental Finand Mental Finand Fina

it. Pages 1 and 2 rtment of Health a rtant: If itam 27 is

permit.
Departn
Imports
any inju

Physician

/Medical

Examiner

Maryland 21215-0036

Baltimore.

State Registrar

29c. License number 29b. Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30) anokn

31. Date filed (Month, Day,

32. Registrar's